

A thesis submitted in partial fulfilment of
the requirements for the degree of
Doctor of Philosophy

Campbell, C. 2009. *Talk about homeopathy: discursive strategies as ways to continually marginalise homeopathy from mainstream acceptance*. PhD thesis. Queen Margaret University.

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TALK ABOUT HOMEOPATHY: DISCURSIVE
STRATEGIES AS WAYS TO CONTINUALLY
MARGINALISE HOMEOPATHY FROM
MAINSTREAM ACCEPTANCE

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A thesis submitted in partial fulfilment of the
requirements for the degree of Doctor of Philosophy

QUEEN MARGARET UNIVERSITY

2009

Abstract

Traditionally, quantifiable research into homeopathy has largely focused on its effectiveness compared to forms of mainstream medicine. The effect of such comparisons is that homeopathy is commonly constructed as not being demonstrably effective. It becomes discredited, demarcated and downgraded as an alternative 'type' of practice, subsequently marginalised in terms of mainstream acceptance. Qualitative studies concerned with homeopathy and focusing on notions of personal credibility, demarcation and the marginal are primarily concerned with practitioners' perspectives, where views are taken for granted and regarded as representative of accurate events. Thus, no study has focused on and investigated social constructions of homeopathic practice derived from practitioners, and their patients, in the semi-structured interview and in the context of the homeopathic consultation. Here, I identify and fill a gap in the literature which is currently under-represented.

The corpus of twenty practitioners, seventeen patients and five homeopathic consultations drawn from interview and consultation contexts were recorded and subsequently transcribed verbatim.

The innovative analytical framework is informed by discursive psychology perspectives that focus on accounts as action. Discourse analysis (DA) led to new, original and significant findings about how interpersonal experiences in relation to homeopathic practice are contingently formulated and constituted in interaction and configured over broader discourses. The analytical chapters show how talk about homeopathy is presented via four discursive strategies: by using the communicative competencies and descriptions they do, the participants' factual accounts function to enhance their own individual credibility and that of their practices, defend their practices and attend to the notion of personal accountability as a discursive practice.

For those advocates for homeopathy, managing their personal credibility is accomplished only through sensitive ways of accounting. This reflects the way in which homeopathic practice is located in a culture of scepticism, as an alternative, contested and controversial 'type' of practice positioned on the fringe of the modern medical market. Demonstrating an understanding of homeopathy and their expectations of it as a form of treatment, participants draw upon dichotomised categories attributed to notions of mainstream medicine and homeopathy, combined with various discursive devices to add persuasiveness to their descriptions.

Overall, the originality of the research lies in the application of the innovative interactional DA framework, its broad range of participants and unique findings from within the field of homeopathy. With several implications, it forms a unique interdisciplinary, theoretical, and methodological contribution to the DA literature. It has practical implications for future policy makers, in the education and training of practitioners, and offers ways to approach future research in homeopathic encounters and in parallel health-related encounters such as other CAM therapies, Myalgic Encephalomyelitis or Chronic Fatigue Syndrome and Attention-Deficit Hyperactivity Disorder.

Notably, the transferability of the findings has wider implications for the understanding of other contested, controversial and new medical practices in the ways that mainstream medicine is the taken-for-granted, accepted yardstick for practice. In making this distinction, the paradoxical boundaries of what is and what is not acceptable is seen as a central issue to members' mutually intelligible sense-making practices in everyday medical encounters.

Acknowledgements

There have been many people who have contributed in various capacities and have positively influenced my composition of this thesis. I shall like to take this opportunity to thank those people. First, I express my appreciation to the pioneering discursive work of Jonathan Potter and Robin Wooffitt, who's ideas largely inspired my method of analysis. Having the opportunity to meet them in person and understand their work further, only served to confirm how engaging, sharing and inspirational a contribution they make and have made to discursive approaches and procedures.

Second, I wish to thank all of the 'lay' and 'professional' participants from the homeopathic community for openly sharing their intimate experiences, knowledge and for their fervour towards the study and the topic of homeopathy. I cite them through numerous extracts which provide the unique findings of the study.

And finally my debt to Beatrix for her unmeasured support, encouragement and belief in my ideas and in me personally as a respected social scientist. Finally, I appreciate and thank everybody who contributed either directly or indirectly that I did not happen to mention in person.

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Overview

This present study's particular focus is on participants' talk-about-homeopathy and their specific verbal constructions, which potentially have the wider effect of potentially and continually marginalising homeopathy from mainstream acceptance through interaction. Data collected derived from three sources: face-to-face semi-structured interviews with practitioners; with their patients; and the homeopathic consultative process between both groups. Analysing the talk, accounts and subsequent discourses oriented to in the research interview and consultative settings offers a flexibility with which to explore the participants' constructions more fully than in, say, experimental settings with specific questions and potentially constrained models. I do not propose a new theory and method but, rather, address an under-represented gap in the field of homeopathy, where an established DA framework proposed by Wetherell (1998) and method of analysis informed by Edwards and Potter (1992) provides a re-reading of what participants are 'doing' with their talk, accounts and discourses in mutually intelligible interaction. Within this form of DA, the focus is on discourse as action within interactive social contexts rather than on discourse as the representation of accurate descriptions or truth claims.

Undoubtedly relevant are the personal criteria I bring to this study: a Bachelor of Science (Hons) in homeopathy accredited and validated by the Faculty of Homeopathy and a Post-Graduate Certificate in Complementary Medicine. From a clinical perspective I hold a Specialist Practitioner Qualification in Homeopathy, the Extended Independent Prescribing Certificate—requirements recognised by the National Health Service (NHS) to comply with clinical governance, current policies

and protocols with regards to case taking, diagnosing (in a homeopathic context), and prescribing homeopathic medicines. The training encompassed expertise in case taking, case analysis, diagnosing—in a homeopathic context—and prescribing homeopathic medicines in NHS clinical environments.

I have completed all the theoretical Faculty of Homeopathy exams to Member of the Faculty of Homeopathy (MFHom) level. Collectively, and unsurprisingly, these experiences influenced my choice of homeopathy as a topic. Insightful practice and a theoretical knowledgebase, together with the completion of this thesis, provide me with the theoretical and methodological skills to become a highly capable interdisciplinary practitioner-researcher, knowledgeable in the field of homeopathic practice located in a culture of scepticism through analysis of verbal interaction. It is imperative for the validity of the study, on various levels, that I maintain a neutral analytical gaze. The obvious starting point for this is to apply a precise and replicable analytical framework. I am well placed to fulfil this need.

Thesis Structure

The thesis is structured over the course of nine chapters. In chapter 1, my main concern is to cover briefly the development of homeopathy from a United Kingdom perspective. This is followed, in Chapter 2, by a review of the relevant literature that identifies issues of credibility, demarcation and the subsequent marginalisation of homeopathy in relation to mainstream medicine. Chapter 3 identifies the research gap, explaining how a discourse analytical perspective on homeopathy benefits in contrast to other forms of qualitative data analysis.

In chapter 4, I define the influences on the theoretical and methodological approach and examine context in verbal interaction. A justification of how homeopathic practices can be examined by applying discourse analysis that offers an alternative approach to traditional research methodologies is given. This is followed by a detailed account of Wetherell's (1998) analytical framework and the method of analysis by applying Edwards and Potter's (1992) Discursive Action Model, and positions the study in relation to previous and current discursive approaches. Following from this, the research questions of the present study are addressed. In chapter 5, the research design for undertaking a discourse analytical study is explained as a step-by-step procedure that characterises the everyday practicalities of the study process.

Chapters 6,7 and 8 focus on the analytical findings. Chapter 6 is based on the identification and illustration of two discursive strategies, made relevant through participants' accounts, and the alignment-with-medicine and boosting-the-credibility-of-homeopathy oriented to by practitioners. Chapter 7 is primarily concerned with two discursive strategies oriented to by patients—namely, criticisms-of-medicine-to-justify-homeopathy and managing-homeopathy-as-alternative. Chapter 8 concludes the analytical focus by demonstrating how, to a degree, three discursive strategies oriented to in the consultative process between practitioners and their patients—namely criticisms-of-medicine-to-justify-homeopathy, boosting-the-credibility-of-homeopathy and managing-homeopathy-as-alternative—appear to indicate that similar discursive resources and accounting perspectives are in play in talk about homeopathy as with the research interviews.

Chapter 9 shows how, at a variety of levels, context impacts on what the participants said across data sets by discussing 'bottom-up' and 'top-down' context in

interaction. The analytical claims of the study are discussed by presenting them in the form of broad discursive strategies. In doing so, comparisons with previous studies, with reference to the relevant literature, are drawn. It concludes with a summary of the main analytical points. In the penultimate chapter (10) I demonstrate the research design as rigorous, In this chapter I critically evaluate the present study by discussing four recognised discourse analysis criteria.

In Chapter 11, I reflect on the research process and project the study's contribution. First, I discuss reflexivity and the analyst's role, followed by an outline of my experience in participating in the research interview process. Second, I discuss the theoretical, methodological, education, policy, interdisciplinary and practical implications of the study. I outline its limitations, what I would do differently to improve upon it, future research directions, and consider the transferability of the findings to analogously contentious contexts. Third, a brief conclusion completes my reflections.

Research Questions

From a DA perspective, the main research question and the three sub-questions in this present study inquire and aim to answer:

How do participants construct, negotiate, (re)-produce and sustain their homeopathic practices and with what discursive effects?

The large bulk of homeopathic literature and the initial analysis suggested that homeopathic practice is infused with legitimising, credibility and status issues. Therefore, three sub-questions emerged from the data sets:

Sub-questions

- i) How do homeopathic practitioners attend to the issue of personal credibility and make orientations towards the contested aspects of their practice?
- ii) How do homeopathic patients attend to the issue of personal credibility and make orientations towards the contested aspects of their practice?
- iii) How do both practitioners and their patients in homeopathic consultations attend to and manage the personal credibility of their contested individual practices?

In making this distinction, and in an attempt to address these questions, I formed the aim of the thesis.

Aim of the thesis

It is the intention to provide an initial outline of how, for the very people who advocate and promote homeopathic practice, managing their own personal credibility and the status of homeopathy is accomplished only through specific ways of accounting. Accordingly, through examining contingently formulated verbal interaction, I address some of the ways they display their communicative competencies and understandings of homeopathic practice.

For instance, DA is utilised to show how participants display homeopathy as a contested and potentially controversial knowledge claim, how they structure their talk and how their mutually intelligible accounting activities orient to broad discursive strategies, making relevant their wider socio-political, historical and culturally shared

context. DA demonstrates how, in understanding homeopathic practice and their expectations of it as a form of treatment, participants' tacit communicative resources are deployed to accomplish interpersonal activities relevant to the interactional business at hand. Concurrently, I aim to identify the re-occurring broader discursive patterns participants use to get things 'done' in interaction.

Chapter 1

Development of Homeopathy in the United Kingdom

The main concern in this chapter is to give the unacquainted reader an insight into the context of homeopathy, briefly covering its development from a United Kingdom (UK) perspective. First, the background to current homeopathic practices is outlined, demonstrating how they are portrayed and constructed through homeopathic educational learning materials. Second, conventional, complementary and alternative medicine—and its relation to homeopathy—is defined. Third, the development of the homeopathic practitioner is discussed. In so doing, I argue that this illustrates the fundamental credibility issues pertinent to homeopathic practice, leading to the demarcation of homeopathy in relation to conventional medicine, and resulting in its potential marginalisation from mainstream acceptance.

1.1 Background to Homeopathic Practice

In terms of society, the discourse of medicine is long established and highly powerful, suggesting that the language used to describe and give meaning to health-related ideas and practices reflects the dominant medical discourse (Atkinson 1985; Foucault 1973; 1980). Although homeopathy is a derivative of medicine founded by Samuel Hahnemann (1755-1843) at the end of the 18th century and developed further at the beginning of the 19th century, to date it is presented as having made little impact

on current medical thinking. Rather, writers claim that, by-and-large, homeopathy has remained on the margins of the medical market (Degele 2005; Ernst 2002). When compared to mainstream medical practices, homeopathy can be seen as contributing to a long therapeutic history; by contrast, however, its aims and beliefs are somewhat opposed to the accepted medical ones (Brewster O' Reilly 1996).

1.1.2 Homeopathy as Medicine

Many current scholars describe homeopathy as a *holistic* system of medicine incorporating patient/practitioner interaction and the 'doing' of empathy, stimulating the body's own natural healing capacities (Kent 1990). According to Smith (2003), homeopathy developed as a healing practice in the 18th century, when common medical treatments produced toxic effects and included such clinical practices as bloodletting, blistering, and purging. Homeopathy is based on *unique* principles aimed at improving the health of a patient by the administration of a medicine that is individually selected. It is claimed that this conceptualisation was first mooted by Hippocrates (406-370 BC), described as the 'father of medicine', who observed that disease could be eradicated by medicines that caused similar symptoms. Reputedly, Hippocrates documented the first principles and practices of medicine, believing that health was a state of equilibrium and illness a state of unbalance. His focus was on 'dis-ease', in contrast to the fixed entity notion of disease (Fulder 1996; Swayne 2000).

In the homeopathic approach, medicines are individualised according to the totality of the person's physical, emotional, and mental symptoms¹. In other words, cosseted within the homeopathic paradigm, the objective is to treat the whole person in their environment rather than making the disease the prime focus. It is argued that a patient's condition results from a complex interaction of physical, emotional, dietary, genetic, environmental, lifestyle, social and other mutually relevant factors, all of which homeopaths take into account when treating the individual as a whole (Boyd 1989; Leckeridge 1997). This perspective is cosseted within a patient-centred holistic system. Accordingly, Leckeridge (1997) claims that homeopathy is based on the following two basic principles: treatment of 'like with like' and the use of the minimum dose, which are integrated into homeopathic philosophy and are key components of the preparation of homeopathic medicine.

Writers argue that the Hahnemannian-influenced therapeutic system was named homeopathy from the Greek notion *homoios* ('like') and *patheia* ('suffering')—thus 'similar-suffering'. Central to the practice of homeopathy remains the first fundamental principle known as the 'law of similars' or 'let like be cured by like', derived from the Latin phrase and conceptualisation *similia similibus curentur*. This is based on the homeopathic notion of treating the person with a medicine that can cause the identical symptoms of the complaint and the belief that the body's own healing and regenerative capacity can be elicited to restore optimal health (Boyd 1989; Swayne 2000). Moreover, Chatwin (2002) identified that Hahnemann, during his medical practices in Leipzig, Vienna and Erlange, came to the conclusion that mainstream medical treatments were potentially detrimental to patients—as discussed

¹ 'Totality of symptoms' means the complete clinical picture of the person during the illness, and comprises all the mental, general, local, and complete symptoms from which the simillimum must be found (Swayne 2000:216).

in his 1786 work *Über die Arsenikvergiftung: ihre Hilfe und gerichte Ausmittlung* (On Poisoning by Arsenic—Its Treatment and Forensic Detection).

This accumulation of knowledge reflected Hahnemann's pioneering and experimental work in the 18th century on the investigational use of cinchona bark (quinine) as a treatment for malaria. Hahnemann took a toxic dose of quinine and observed that it displayed similar symptoms to malaria. This demonstrated that a dose of a substance that is known to cause similar symptoms of the presenting complaint could be administered to counteract symptom manifestations. The subtle differentiating mechanism, unique to homeopathy, is that homeopathic preparations of a specific substance adopt a system of specially diluted minute doses of medicinal substances to affect a curative effect (Leckeridge 1997). It is hypothesised that the mechanism(s) by which the information/message/signal, carried by the homeopathic medicine renders homeopathy biologically implausible because of the use of medicine diluted beyond is transformed into a series of biological action that bring back the organism into the path of recovery from the diseased/disordered state (Khuda-Bukhsh and Pathak 2008).

The second basic principle is the potentisation² of homeopathic medicines. That is, homeopathic medicines are prepared through a process of serial dilution, drawing on the minimum dose at infinitesimal dilutions. It is argued that the higher the dilution the greater the potency and thus the increased therapeutic power of the dynamic elements of the medicine on the dynamic vital force³. Again, this process is inherently at odds with mainstream medical practices. However, as the origin of disease occurs on this energetic level, the homeopathic medicine has also to be on similar energetic level, for which potentisation of homeopathic remedies is done by

² A multi-step preparation of the homeopathic medicine involving serial dilution with succussion (Swayne 2000).

³ 'Vital force' is a metaphysical rather than a biological or biophysical concept (Swayne 2000:126).

dilution and succussion and the method of preparation is believed to impart considerable energy to each part of the medium/substance/vehicle (Khuda-Bukhsh and Pathak 2008). In addition, this principle allegedly renders homeopathy biologically implausible because of the use of the medicine diluted beyond the Avogadro⁴ limit (Aabel et al 2001; Lancaster and Vickers 2000).

1.1.3 Homeopathy as Energy

In homeopathic terms, the scientific, electromagnetic, probabilistic field of energy is known as vitalism⁵. This is part of the vital force⁶, otherwise known as a balancing mechanism that incorporates concepts as varied as quantum physics and cellular automata perspectives; each of them lie within the boundaries of complexity theory (Bellavite 2003; Casti 1994, 1996; Fontana and Buss 1995). This micro process is considered to be mediated by structural modification of water, analogous to storage of information by magnetic media. Thus, demonstrating such information is retained in physical, rather than chemical form. In other sets of experiments involving Nuclear Magnetic Resonance (NMR) or Fourier Transform Infra-red Spectra (IR) where structural differences between homeopathic potencies and solvent ethanol have been identified. Consequently, offering areas of potential explication and validation of the effects of highly diluted homeopathic medicines (Aabel et al 2001; Khuda-Bukhsh and Pathak 2008).

⁴ It is not possible to detect the physical presence of any particle beyond a dilution of Avogadro's number (Swayne, 2000:22).

⁵Vitalism is a metaphysical aspect of homeopathic medicine. It is an energy closely related to the concept of the life force, a vital principle that energises, sustains, directs and integrates its functions (Swayne 2000: 225).

⁶Vital force is a metaphysical rather than a biological or biophysical concept (Swayne 2000:126).

From alternative perspectives, this notion of vitalism is said to be on a par with the concept of *ch'i* (yin and yang), while the ways they constitute the life force is equivalent to the universal cosmic energy perspectives of Eastern religions (Smith 2003).

1.2 The Proving: A Homeopathic Pathogenic Trial

It is postulated by Brewster O' Reilly (1996) that Hahnemann further developed the core principles of homeopathy in a research method known as *proving*. By discussing the arguments put forward in defining the proving, I demonstrate how the basic principles are viewed as essential to the discovery of new homeopathic medicinal products.

This procedure makes the claim for homeopathic medicines having clinical efficacy; it amounts to collecting evidence of the clinical and therapeutic effects—the homeopathic medicinal properties—of a substance. The proving process is similar to a Phase I clinical trial. But the subtle difference is the fundamental homeopathic ‘like cures like’ principle. To reiterate: the homeopathic medicinal properties of a substance cause the illness’s symptomatic picture. Significantly, as the substance is tested on prospectively healthy volunteers, it does not alleviate symptoms. The medicinal substance apparently only does so when an individual is having symptoms similar to the proven symptomatic picture. When a homeopathic medicine is given to a healthy volunteer, part of the criterion of the proving is that they *will* experience the symptomatic effects specific to that very medicine (Brien *et al* 2003; Lewith *et al* 2003).

The trial period lasts over a timescale of weeks under a structure akin to the conventional double-blind, placebo-controlled, randomised controlled trial (RCT). The

randomised controlled sample consists of homeopathic practitioners and anonymous participants selected to achieve the proving. The experiments are conducted on healthy volunteers in a similar fashion to traditional data collection methods. It is no more than a systematic sequence of events that encompass the homeopathic medicine's whole drug picture. After ingesting a homeopathic medicinal property of a substance, the 'prover' documents a subjective patient-centred description until there has been a satisfactory meta-analysis of the whole clinical picture—indicated by the encompassed symptoms. Additionally, when considering the medicinal effects, Hahnemann apparently acknowledged that it was equally essential for an independent observer to integrate any further etiological, personal and clinical factors, features and characteristics that may have affected, either directly or indirectly, the person's physiology and psychological symptomatic picture during the period of the proving. From this perspective, the proving is arguably approached wholly from a holistic perspective, in the sense that all symptoms observed and described by the participant and observer are considered relevant and documented.

A satisfactory meta-analysis is reached when one identifies a saturation point: no further potential symptoms can be elicited directly from the homeopathic medicinal properties of a substance. During his research, Hahnemann reputedly tested numerous homeopathic preparations of toxic substances, culminating in an extensive record of reproducible therapeutic medicinal effects, which are documented and compiled in written form—known as a *Synthesis - Of Symptoms* (Schroyens 2001). The '*Synthesis*' is a condensed repertory that allows the homeopath access to the numerous 'proved' rubrics⁷ (Boyd 1989; Kayne 1997; Schroyens 2001).

⁷ The rubric: the phrase used to describe and identify a symptom and its component elements (Swayne 2000:186).

Thus, a totality of symptoms⁸ or homeopathic picture in line with holistic ideals is constructed and organised into another reference work known as the *Concordant Materia Medica*, (Vermeulen 1994) which is continually being updated and is referred to as the basis for homoeopathic prescribing in conjunction with the *Synthesis – Of Symptoms*.

1.3 Conventional, Complementary or Alternative Medicine

If the mechanisms discussed above are taken as a literal testimony, then the basic principles fundamentally contrast with conventional medical practices, which are sometimes referred to as traditional, allopathic, orthodox, or mainstream in their approach to alleviating symptoms. In this context, the term ‘conventional medicine’ is considered by Swayne (2000), who advocated:

...It is obviously true that other methods of medicinal practice may be conventional within the culture in which they are applied ... ‘conventional’ is appropriate to contemporary western medicine because of its dominance of healthcare ideology.

(*ibid*: 54)

Furthermore, when discussing homeopathy in this present study it is imperative to provide a definition of the conceptualisation of complementary and alternative medicine (CAM), as homeopathy is often considered synonymous within this spectrum. In addition, it is postulated that CAM is tantamount to therapeutic practices and systems detached from conventional/mainstream/traditional scientific

⁸ 'Totality of symptoms' is the complete clinical picture of the person during the illness, comprising all the mental, general, local and complete symptoms from which the simillimum must be found (Swayne 2000:216).

medicine (Fulder 1996). Apparently, during the 1970s and 1980s such therapeutic disciplines as homeopathy were largely constructed as alternative to conventional or mainstream medicine (Zollerman and Vickers 1999). Hence, the term ‘complementary’ was adopted as the two approaches—homeopathy and conventional medicine—developed parallel to one another. However, they are also described as ‘complementing’ each other. Despite this as a point of reference, in this present study when I refer to homeopathy/alternative medicine/CAM I shall draw upon Zollerman and Vickers’s (1999) working definition through the Cochrane Collaboration:

Complementary and alternative medicine (CAM) is a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period. CAM includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and well-being. Boundaries within CAM and between the CAM domain and that of the dominant system are not always sharp or fixed.

(*ibid*: 693)

This definition serves to illustrate a consensus among academic journals and political papers of where homeopathy lies within the description of CAM (House of Lords Select Committee on Science and Technology 2000; Walach *et al* 2002). Significantly, drawing attention to CAM as described above—‘other than those intrinsic to the politically dominant health system of a particular society’—is considered a key point when referring to homeopathy within this context.

1.3.1 Homeopathy Located On the Margin

Homeopathy is not considered a politically dominant form of treatment; rather, it is demarcated and positioned outside of the current system, which presents it as

marginalised (McCarthy 2005). Consequently, when being evaluated as a CAM, homeopathy is presented in a contrasting role to conventional medicine, which serves to undermine the potential for homeopathy to be accepted as a discipline in its own right. Repeatedly, scholars, through academic journals, willingly position homeopathy under this CAM umbrella and on the periphery of conventional medicine (Frank 2002a; Fulder 1996).

To further perpetuate the notion of marginalisation, Ernst (2002a) argues that the exact reason for the use of homeopathy as a CAM amounts to a criticism of the modern health care system. However, Ernst does recognise that there is no single determinant of the present popularity of homeopathy and CAM. Rather, there are both positive and negative determinants. The positives include perceived effectiveness, perceived safety, philosophical congruence, control over treatment, affluence, and a good patient and practitioner relationship. On the downside, dissatisfaction with conventional healthcare, serious adverse effects from drugs, poor patient and practitioner relationship, waiting lists, rejection of science and technology, rejection of the establishment, and desperation are presented as negative determinants.

1.3.2 Marginalisation to the Medical Institution

Here, I draw on the Foucauldian (1970; 1973; 1980) notion of marginalisation—the ‘scientific’ institution as a metaphor—to constitute the ‘What is?’ and ‘What is not?’ wider scepticism about the validity of homeopathic practice. The notion of marginalisation is present when a dominant majority is at the centre of the legitimisation of the institution (conventional medical practice) with diverse marginalised practices represented at the periphery (homeopathic practice as an

‘alternative’ type of practice). The boundaries of the institution are defined by ‘acceptable practices’ that are negotiated, resisted, made relevant and sustained by the members’ methods of sense-making. The notion of what is an acceptable, taken-for-granted or ‘normative practice’ is socially constructed and constituted over multiple discourses. In other words, through their talk, participants rely on mutually intelligible culturally shared meanings and expectations when (re-)producing their communicative competencies, accounting practices and actions. In so doing, the effect of marginalisation varies between interactional contexts, settings and type of medical encounter. Foucault claims that the development that configures and maintains the continuity of medical discourse as a dominant truth claim/scientific knowledge/metanarrative is a culturally shared, socio-political, historically informed production and not solely a socially neutral phenomenon.

1.3.3 Credibility Issues

It could be argued that positioning homeopathy as CAM with other therapies on the boundaries of conventional medicine continues to undermine homeopathy’s mainstream acceptance. Homeopathy in this context is orientated too as part of the deviant or obscure approach in health care that has yet to prove itself scientifically (Baggot 2004). Although there is evidence to suggest that homeopathy has a scientific base, it is frequently lacking in credibility owing to the implausibility of the homeopathic doctrine, which is contrary to conventional medical principles (Degele 2002; 2005). In so doing, homeopathy has long had critics. One critic in particular, namely Skraabanek (1986), described the homeopathic principles as no more than ‘dilutions of grandeur’. Furthermore, Vanderbroucke (1997) suggested that

homeopathic research is no more than a randomised trial of a game of luck that involves two inactive substances, explicitly stating that a homeopathic study is no more than an evaluation of ‘solvent only’. A paper by Vanderbroucke (2005) reiterated that homeopathic theory was ‘an outrage to human reason’. As these arguments develop, the ‘case against’ homeopathic approach continues to gather momentum.

1.3.4 Biomedical Scepticism of Homeopathic Efficacy

Consequently, ‘the end of homeopathy’ is cited by biomedical scientists as a direct attack against homeopathic efficacy (The Lancet, 2005). The specific source for this claim is drawn from findings in a study by Shang *et al* (2005) which, without question, positions homeopathy as a contested controversial medical practice located in a culture of scepticism. In considering these points, one must ask whether science in the conventional medical paradigm is the most appropriate tool for research into the homeopathic process. Moreover, the discursive construction of medicine has consequences not just for itself but also for all CAM approaches. These medical constructs are played out at a social level. Taking this perspective into account, interaction and society are in many respects effectively the same, the dominance of medicine and the inferior status of CAM therapies—and specifically homeopathy—are ‘made’ discursively relevant in everyday life and that leads to this dominant form of medical discourse. In many contexts, health practitioners and service users through their discourse draw upon metaphors and a register of terms congruent with the biomedical approach when making such comparisons with homeopathy (Degele 2002; Lewith and Aldridge 1993). It may be argued that it is simply a reflection of the

dominance and availability of such medical ideology that it is produced and sustained in the majority of healthcare settings, resulting in homeopathy presented as a contested and controversial knowledge claim in contrast to mainstream medical practices.

1.4 Practitioner Development

Although the practice of CAM and subsequently homeopathy is widespread, it is not regulated as such, but is governed by two main professional bodies. It is recognised by the National Health Service (NHS), but has remained an area of great controversy owing to its method and treatment ideology. As a result, homeopathy is again placed on the periphery of modern medical practices.

1.4.1 The Faculty of Homeopathy

As observed by Swayne (2000), in 1844 Dr Fredrick Quinn founded the British Homeopathic Society in London. Apparently, because of his aristocratic connections, he was successful in raising funds in 1849 for a Homeopathic Hospital in London. Subsequent other hospitals in Bristol, Glasgow, Liverpool and Tunbridge Wells were incorporated into the NHS at its inception in 1947. Their accrediting body is the Faculty of Homeopathy. The Faculty was incorporated as an Act of Parliament in 1958 and has over one thousand four hundred members. The Faculty issues diplomas of fellow, member and licensed associate (FFHom; MFHom; LFHom) to statutory registered practitioners, including doctors, nurses, pharmacologists, podiatrists, dentists, and veterinary surgeons. In 2003, the total amount of doctors who

have undertaken postgraduate training in homeopathy and received the appropriate award was five hundred and seventy five (Faculty of Homeopathy 2003). Faculty members acquire a degree of independence as complementary practitioners within the guidelines set by NHS policies and protocols, and primarily practice as an *adjunct* or *subsidiary* to conventional medicine.

1.4.2 The Society of Homeopathy

In contrast, a distinguished group of non-medically trained homeopathic practitioners set up a College of Homeopathy in 1978 and subsequently the Society of Homeopathy (SOH) in 1981, primarily for non-conventionally trained homeopaths. This body grants registration to professional homeopaths (RSHom; FSHom). Currently there are over one thousand registered members on the SOH register (Cant and Sharma 1996; Society of Homeopathy 2004; 2004a). There are also a number of non-medically qualified practitioners who are members of the Homeopathic Medical Association and the Alliance of Registered Homeopaths (Faculty of Homeopathy 2003). Consequently, the Department of Health responded to the House of Lords' Select Committee Report on CAM to work towards a process of appropriate professional regulation for doctors, allied health and non-medically qualified CAM practitioners (Lewith *et al* 2003).

1.4.3 Areas of Tension Entangled between Practitioners

There are acknowledged tensions within the medical profession between homoeopathically influenced doctors and orthodox doctors due to issues of credibility

and the lack of reliable research evidence (Ernst 2002; Shang *et al* 2005). Numerous scholars have observed that homeopathy has never been able to compete and thus sits somewhat uncomfortably within the professional framework of conventional medicine (Degele 2005; Frank 2002a; May and Sirur 1998). Furthermore, there are numerous independent homeopathy practitioners outwith the boundaries and membership of the main professional bodies. Tensions between all these groups are due to issues of regulation, credibility, status, training, expertise and authenticity within the discipline.

While homeopathy is presented in New Age settings or at psychic fayres, strictly scientific homeopaths often set themselves apart because these other groups' diagnostic techniques are drawn from diverse methods such as divination, astrology, and pendulum swinging. These hotly contrasted ideological disagreements between homeopaths, doctors and academics are ongoing—produced and sustained over a broad social arena (Frank 2002; Smith 2003). As a result, the development of homeopathy as a unified discipline in its own right, thus potentially strengthening its credibility, fails to materialise.

1.5 Conclusion

At this point in my argument, I demonstrate through a description of homeopathic learning materials how homeopathy is a derivative of conventional medicine with opposing mechanisms. As a result, homeopathy is placed under the CAM umbrella and positioned on the fringes when explicitly contrasted with notions of mainstream medical practices.

I argue that the development of the homeopathic practitioner involves being governed by two main professional bodies that have contrasting views regarding their everyday practices. I acknowledge that statutory registered professionals who practice homeopathy have a degree of independence within the NHS as CAM practitioners. However, the main organisations require practitioners to hold professional indemnity and public liability insurance and abide by a code of ethics. This undoubtedly gives weight to the professionalisation of the discipline as a whole.

Overall, by highlighting the conflict between medically trained and non-medically trained homeopaths within the community, I identify tensions between those practitioners who align with mainstream medicine and state registration in the guise of a doctor or allied profession and those who are non-statutory registered practitioners.

Consequently, this process contributes to aspects of social exclusion by fragmenting homeopathy as a discipline in its own right and, at the same time, this exclusion works to present homeopathy as a contested, controversial and troubled form of treatment on the periphery of mainstream medical practice. In identifying this ongoing tension and subsequent misalignment between practitioners, this potentially ‘discursive site’ generates a rich area within which to explore—at a micro-interaction and macro level and engaging with post-structuralism—homeopathic practice.

Chapter 2

Literature Review

The main concern in this chapter is to review and focus specifically on the relevant literature that identifies intertwined issues in relation to credibility, demarcation and the subsequent marginalisation of homeopathy. There are, however, pertinent reasons for choosing to follow this line of inquiry. First, in the challenge of locating reliable literature in homeopathy, I outline the approaches taken to address bias in the publication of CAM research.

Second, reviewing key qualitative studies highlights the ways in which homeopathic practice is located in a culture of scepticism and subsequently positioned as marginalised in terms of mainstream acceptance. On the face of it, I demonstrate how the findings from these studies relate directly to and contribute to the overall aim of the thesis.

Third, this is followed by the identification of the gap in the literature in which I propose to apply discourse analysis. Here, I demonstrate the strengths of applying discourse analysis as compared to other forms of qualitative data analysis and argue that discourse analysis is the most appropriate method for this present study.

2.1 Inclusion and Exclusion Criteria for Homeopathic Literature

To begin, I give a version of the challenges that I experienced in identifying quality studies in CAM and, more specifically, homeopathy. There are biases in the

publication and indexing of CAM research that ultimately presents difficulties in locating reliable work. Shekelle *et al* (2005) argue:

Publication bias refers to the tendency of investigators, reviewers, and editors to submit or accept manuscripts on the basis of the strength or direction of the findings.

(*ibid*: 1042. Original italics)

In CAM research the majority of studies published show positive results that are particularly published in CAM oriented journals. Therefore, this imbalance may reflect a publication bias. On the contrary, negative CAM findings are recurrently published in mainstream medical journals (Shang *et al* 2005). Positive CAM findings are more likely to be published in CAM topic journals, whilst the direction of bias depends on the topic of the CAM therapy. Another area of widespread bias in CAM is the incomplete indexing of CAM journals and articles by mainstream databases such as MEDLINE. MEDLINE are reported as indexing a disproportionate amount of all CAM journals identified by the National Centre for Complementary and Alternative Medicine in contrast to all other biomedical journals published. Furthermore, the inconsistent use of keywords, descriptions and subject headings poses a challenge in identifying relevant CAM literature, (Shekelle *et al* 2005).

Taking these potential areas of bias into account, to access relevant CAM literature I conducted my search in both specialised CAM databases and mainstream databases. The terms ‘CAM’ and ‘homeopathy’ did not feature simultaneously in the article titles but did feature in mainstream databases, and did not capture all studies relevant to CAM or, more specifically, homeopathy. In searching, I was not interested in primarily positive results in CAM or homeopathy, as these proved to reflect studies that applied methods primarily associated with the randomised clinical trial that

offered findings in traditional research. These particular studies did not provide information to answer the qualitative approach or indeed the research question in this present study.

2.1.1 Search Strategy and Study Selection

The search strategy involved the search engine ATHENS, which covers a wide range of databases offering articles covered by the social and medical sciences and in the homeopathic genre, such as AMED, CINAHL, EMBASE, HOMIN-FORM-British Homeopathic Library, HOMEON-DEX, MEDLINE AND PsycINFO. In identifying specific homoeopathically informed articles, the database Hom-Inform carried relevant literature. However, the downside again was that the articles predominantly focused on findings related to the positive biological plausibility of homeopathy. The key words ‘homeopathy’, ‘credibility’ and ‘marginalisation’ proved fruitful in Google Scholar. Initially, I identified a conference paper by Degele (2002) that addressed this topic. As an interesting line of inquiry, I communicated with the author for additional feedback and direction for previous and current relevant studies. Subsequently, I identified a more up-to-date study by the same author that offered insights into a qualitative social-science perspective on the marginalisation of homeopathy (Degele 2002, since published as Degele 2005). Through the provision of information from Degele’s study, and by reviewing the reference list, I cited further similar studies that reflected participants’ views regarding homeopathic practice from the context of its demarcation and marginalisation from mainstream medical practices. From this I sourced qualitative studies by Frank and Stollberg (2001) and Frank

(2002; 2002a), with whom I had a face-to-face meeting where we discussed research design in doing qualitative research in homeopathy.

This method proved fruitful in accumulating the appropriate literature that would provide a context for my study. During my search, I concluded that there are very few qualitative studies published in homeopathy and particularly on the topic of marginalisation, but more with a subtle focus on credibility issues. Rather, studies identify this notion as part of a wider exploration, but primarily focused on why practitioners and their patients use homeopathy.

Furthermore, another hurdle to identifying quality research in homeopathy is that the research tradition and research infrastructure are underdeveloped. However, in the area of the randomised controlled trial several researchers have attempted to demonstrate that homeopathy has produced favourable results when contrasted with placebo or with another medication, or where clinical outcomes have been recorded following homeopathy in routine practice (Reilly and Taylor 1985; Reilly *et al* 1986; Reilly *et al* 1994; Taylor *et al* 2000). The downside of these findings is that it has had limited impact in convincing the medical market of efficacy (Shang *et al* 2005; Skraabanek 1986).

In assessing the wider perspective, everyday homeopathic practice has a heritage that is largely opinion-based, making it difficult to identify quality researched studies that reflect the day-to-day views of homeopathic practice (Ernst 2000). Therefore, I begin my review by drawing upon information from prominent homeopathic literature demonstrating that credibility issues, status and demarcation in relation to mainstream medicine lies at the root of the homeopathic approach.

2.1.2 Homeopathic Research

The status that mainstream medicine has achieved has consequences for all sorts of social actions that legitimise the acceptance of particular ways of constituting social reality about health practices and illness (Baggot 2004; Nessa and Malterud 1998; Seymour-Smith *et al* 2002; Stiles 1996; Youssef and Silverman 1992). Homeopathy can also be seen as contributing to a long therapeutic history, but its aims and beliefs are somewhat opposed to the accepted medical ones (Brewster O'Reilly 1996). In so doing, such groups of 'medical outsiders' are deemed to be discredited, marginalised and without an influential political voice (Degele 2005).

Traditionally, homeopathic studies attempt to prove aspects of clinical efficacy in an effort to make an impact in the wider medical market with the aim of boosting the credibility of homeopathy. This is mainly due to the lack of a credible research base into homeopathy (Colquhoun 2007; Giles 2007). Ernst (2000) argues that CAM and homeopathy lack a research tradition and the research infrastructure therefore fails to attract experienced researchers. Consequently, the funding of research is dismissed. This notion is perpetuated over decades and highlighted by Swayne (1998), who observed that the majority of homeopathic research focused principally on the double-blind, placebo-controlled, randomised controlled trial (RCT). In this context, the RCT method is deployed to add persuasive value to the benefits of the medicinal effects of homeopathy. Swayne (1998) advocated:

All research emphasis in homeopathy is directed towards proving that the prescription 'works', - that the medicine is an active therapeutic agent.

(*ibid*: 198)

2.1.3 Qualitative Studies in Homeopathy

Contrary to this view, several qualitative studies consider homeopathic practice from a social science perspective (Cant and Calnan 1991; Cant and Sharma 1996; Degele 2005; Frank 2002). Although there were none where they applied discourse analysis. In these studies the main concern is with practitioners' views on the credibility and status of everyday homeopathic practice, which is contrasted with everyday medical practices and found to become demarcated and marginalised in terms of mainstream acceptance, particularly in Degele's (2005), work where she argues explicitly that homeopathy is still positioned within a marginalised field.

2.1.4 Achieving Legitimacy in Homeopathic Practice

Taking this perspective into account in a longitudinal study with regard to the professionalisation of homeopathy, Cant and Sharma (1996) consider the activities of the professional associations. As a way of generating findings, they contrast the knowledge claims of medically qualified homeopaths with non-medically qualified homeopaths over a two-year period. The two groups primarily consist of members drawn from the Society of Homeopathy and the Faculty of Homeopathy respectively. In so doing, Cant and Sharman argue that each group responds in different ways to achieve legitimacy, status and authority in the wider mainstream medical market. Specifically they assess the strategies each group uses to demarcate homeopathic knowledge from orthodox medicine.

Data was collected through the research interview with twenty key members of the homeopathic associations, followed by attending conferences and conducting

secondary analysis of their journals and newsletters. Questionnaires were sent to all colleges that were not visited. Further interviews with umbrella groups representing CAM were carried out. There was no detail of the type of interview or of the technique used to achieve data collection. However, Cant and Sharman's findings provided a novel insight into a struggle played out in the professionalisation process of homeopathy.

Cant and Sharma argue that a strategy of professionalisation adopted by practitioners is intended to enhance the status, legitimacy and credibility of homeopathic practice. In identifying this strategy, they demonstrate a process of struggle that both groups are involved in regarding professional status and credibility. Moreover, a topic resisted by non-medically trained homeopaths is the development of homeopathic methods in a biomedicine context, i.e. medically qualified homeopaths are interpreting homeopathy by distancing themselves from traditional homeopathic knowledge and aligning with mainstream notions of medicine as a compromise. Non-medically qualified homeopaths view this orientation to medicine as discrediting what stands as homeopathic knowledge, in the anticipation of gaining aspects of credibility. The non-medically oriented homeopaths claim to teach homeopathy in a profound way and avoid the biomedical pathological approach. By contrast, Cant and Sharma argue that medically trained homeopaths embark on a strategy of 'pick and choose'.

In so doing, they are viewed as de-emphasising contested and controversial topics of homeopathic philosophy in favour of orienting towards the tenets of orthodox medicine as a way of boosting the credibility of homeopathy. Regarding regulation, Cant and Sharma argue that it may position homeopathy as subordinate to

orthodox medicine, claiming that the orthodox profession would not allow autonomous practice. Medically qualified homeopaths are quoted as stating:

They (non-medically qualified homeopaths) need to work within their boundaries and not take chances...we think that homeopathy is medicine and should be practised by people who have received a proper training, now this is changing in lay homeopathy but they need adequate medical training.

(*ibid*: 583)

In making these claims, Cant and Sharma argue that non-medically qualified homeopaths are possibly unsafe with regards to their homeopathic knowledgebase. Maintaining that medically qualified homeopaths align the non-medically homeopaths with the category of 'lay homeopathy' is a way of castigating the non-medical approach to homeopathic practice. In contrast, there has been a consistent effort from both groups to attach themselves to the scientific paradigm as a way of bolstering credibility. This attachment operates by attempting to locate the method through scientific research and biophysics. Previous research by Taylor *et al* (2000) attempted to demonstrate positive results in contrast to placebo. Principally, the hypothesis questioned homeopathy versus placebo in perennial allergic rhinitis as a randomised double-blind, placebo-controlled study of two parallel groups. The results reinforced the position that homeopathic dilutions are favourable over placebo. Again, in an attempt to align with the scientific paradigm, homeopathy is positioned as potentially subordinate to conventional medical practice.

When considering 'the lay public', both medically qualified and non-medically qualified homeopaths suggest that patients seek homeopathy because they are critical of and disillusioned with scientific and technocratic medical practices. They maintain that patients looking to use homeopathy want more autonomy about health and positive interaction with their homeopath during consultations. Subsequently, patients

seek homeopathic treatment when all else has failed, being particularly critical of orthodox practices. Moreover, scientific research and clinical legitimacy is not suggested as the explanation of why patients use homeopathy.

It has been argued that the boundaries between non-medical practitioners and the lay public are permeable. That is, non-medical homeopaths are portrayed as non-hierarchical, encouraging patients to self-prescribe with first aid kits as a way to make homeopathic medicines accessible and acceptable and allowing patients to take more responsibility for their health. In contrast, medically qualified homeopaths maintain that aspects of orthodox practice and homeopathy should be combined. However, in making those claims, orthodox practitioners are unlikely to allow autonomous prescribing and practice without a medical background. In so doing, this approach would exclude non-medically trained homeopaths.

The findings show that by attempting to achieve a higher status and building up credibility concerning homeopathic knowledge, the potential downside is alienating patients and demarcating homeopathy's position as subordinate to orthodox medicine.

Consequently, Cant and Sharma (1996) argue that the future professionalisation process of homeopathic knowledge is uncertain, as the analysis is concerned with the problematic professionalisation for both groups. What the study shows is how a strategy of professionalisation can potentially work to separate two groups of homeopathic practitioners (non-medically trained and medically trained), and separate patients from practitioners. In an attempt to enhance realistic legitimacy, homeopathy overtly becomes positioned as marginal to orthodox practices and the wider medical market.

2.1.5 Defining Demarcation Strategies in Homeopathic Practice

In another line of research, Frank (2002) focused on the relationship between homeopathic physicians and their patients to define demarcation strategies and collect evidence of why patients look to homeopathy. Here, Frank claims that the homeopathic approach is identified as offering potential therapeutic benefits, particularly as a patient-centred treatment—in contrast to criticism of biomedicine, where the orthodox physician relies on the technicalisation of the consultation process. In contrast, the homeopathic consultation is presented as a more egalitarian relationship between physician and patient, where the negotiation of psycho-social issues and the patient's narrative is a principal focus in defining the patient's current health status. This study was particularly useful in highlighting a strategy that patients adopt in their descriptions regarding choosing homeopathy and at the same time identifies a demarcation between it and orthodox medicine.

Data was collected through a semi-structured interview technique. This led to the audio-taping of interviews with homeopathic physicians. The interview transcripts were analysed using cross-case analysis as well as individual analysis, as a way to identify descriptions of factors that have the potential to influence the development of homeopathic practice.

Patients provided various descriptions for using homeopathy, and some were positive about taking an interest in their health, looking for a spiritual dimension, or as a matter of principle. However, it was apparent that an undisclosed but apparently significant number of patients described their reason for using homeopathy as disenchantment with conventional medicine. Positively, this study focuses holistically on the person, drawing on contemporary concepts from the social sciences, medical

sciences, and psychology. Negatively, homeopathy is positioned as discredited—a fringe form of treatment where the patient considers homeopathic use after the rejection of orthodox medicine following an apparent unhelpful experience of it. In making these claims, biomedicine is viewed as the principal yardstick for practice.

Therefore, in the strategy '*Perceived characteristics of homeopathic patients*', Frank (2002) identifies the ways in which homeopathic physicians describe their patients as exceptionally critical towards biomedicine. This is particularly prevalent among patients who describe the disillusionment with side effects and the inefficacy of biomedical drugs. This is critically appraised and offered as a motivating factor to begin to look to homeopathy. Furthermore, criticisms referring to disillusionment with biomedicine were expressed by patients who used homeopathy as a final treatment option. Frank identified a whole group of patients who use homeopathy for these reasons. Homeopathic physicians reinforce this notion by describing patients' use of homeopathy with statements drawn from the empirical data such as:

'A lot of people come: they have tried everything and end up in homeopathic practice. Like asthmatics, like rheumatics, people who have tried everything, nothing was helping them and now they give homeopathy a go.' (physician 12)

(*ibid*: 1289)

'You are my last hope'. Or 'I have tried everything else'. Or 'I don't know what on earth I should do.' (physician 17)

(*ibid*: 1289)

'Patients with chronic diseases who have been suffering a lot. These are often patients who have been ill for ten or fifteen years and choose a different approach now.' (physician 8)

(*ibid*: 1289)

In this study, Frank took a physician-centred approach that proved fruitful in identifying an emerging feature of patients looking for homeopathy, which he claims has the appearance of a demarcation between orthodox and the homeopathic practice. However, in taking this ‘last-resort’ type of position, patients are viewed as defining homeopathic practice as lying outside the prevailing scientific mainstream and in many ways this establishes the credibility of homeopathy as a viable treatment only to be used when all else has failed.

A limitation of this study was that data was from one source. Such research could be complemented by examining perspectives from homeopathic practitioners, patients and homeopathic consultations, which are argued by Frank as having, to date, been poorly researched. It might have served the study better if Frank had interviewed patients rather than physicians. In so doing, Frank suggests that negotiations between the practitioner and patient could present a broader picture of the prevailing contested issues regarding the homeopathic physician and patient relationship in everyday homeopathic practice.

2.1.6 Locating the ‘Alternative’ Practitioner

In an exploratory qualitative investigation of the perceptions of alternative practitioners, Cant and Calnan (1991) examine the role and position of non-orthodox medicine within the medical market when contrasted with orthodox medicine. Here, Cant and Calnan (1991) explore how alternative practitioners’ views and images of their work are portrayed in general. Although the study was set in the early 1990s, it touched upon similar topics that prevail, namely credibility issues and the subsequent demarcation of homeopathic practice.

All practitioners were members of recognised organisations. The practitioners were from two towns in South East England. Emphasis was made highlighting that the sample was not representative. Practitioners who worked solely within the NHS are not represented. This suggests that the use of the title ‘homeopath’ indicates that the sample represented non-medically trained homeopaths (although this is not stated within the study). Specialities were chosen to represent a broad spectrum of the CAM market. They included a chiropractor, naturopath, osteopath, homeopath, reflexologist, herbalist, hypnotist, acupuncturist, and spiritual healer. The distinction between homeopathy and spiritual healing exemplifies the disparity between practitioners. The sample size limits the scope of the analysis for generalisability purposes. However, the findings are arranged to represent informed propositions that are generalisable based on the inferences made.

All practitioners were invited to participate in semi-structured interviews with a degree of disparity, represented in the broad spectrum by terms of varying cosmologies and social acceptability. All interviews were audio-taped, transcribed and analysed to identify themes and strategies adopted by the practitioners. Two themes were identified in which the practitioners defined their role, namely as *The position and role of ‘alternative’ medical practice* and *Professionalizing alternative practice*.

The findings suggested that alternative practitioners could not be treated as a homogeneous group, as each offered a different kind of treatment. It is argued that the generic CAM title is a misleading label. This is presented as a reasonable claim as each discipline offers such a varied therapy. Specifically, homeopathic practitioners described a conflict of philosophy that was incompatible with orthodoxy and, on this basis, saw their role as alternative. As a collective group, however, alternative practitioners viewed their future development as that of therapists practising on equal

terms with the medical field by adopting various degrees of conventional medicinal principles to promote a professional and credible status.

The first theme identified as *The position and the role of 'alternative' medical practice* was used to ascertain how homeopathic practitioners viewed their role. Specifically, the views solicited included how they felt regarding general practitioners (GPs), the route patients took in coming to them, and the attitude taken towards patients. One homeopath argued that although GPs' opinions varied, they did emphasise the homeopath as alternative. The GPs' views were particularly critical, claiming:

'Negative feelings from GPs were explained in terms of their ideology, which designates anything other than orthodox medicine as unscientific and because alternative medicine stands as a threat they viewed us quite negatively as 'the alternative therapist.' (homeopath)

(*ibid*: 42)

'The comments show that GPs viewed the homeopath as alternative, demonstrating an aspect of hostility. This was the general pattern in alignment with the other alternative practitioners unless the GP practiced homeopathy, experienced the treatment or wanted to reduce the patient load.' (homeopath)

(*ibid*: 113)

Homeopaths said that patients came to them prompted by adverts in the *Yellow Pages* or word of mouth, but a common route was explained as the 'last resort'. The 'last resort' was a theme that consisted of explaining the failure of conventional medicine, scepticism of drugs, and the desire for a longer consultation. The theme was also given as an explanation for practitioners developing an interest in homeopathic practice. This notion is portrayed as:

‘I think a lot of people come who have been treated by their GP, who had a lot of drugs, steroids etc...and then they say, ‘well, I have tried everything else, now I’d better try homeopathy...but the bulk come because they are dissatisfied with their GPs, which is the very reason I turned to homeopathy, because of my experiences.’ (homeopath)

(*ibid*: 44)

As a way of boosting the credibility of homeopathy, a homeopath talked about collaborating with a GP in the treatment of a patient with a mental health problem. Conventional medicine was seen as limited, so the notion of a holistic approach was considered a positive option. The homeopath talked up homeopathy as offering a wider approach to the patient’s health status in contrast to conventional medicine, stating:

‘It’s holistic medicine, we deal with the mental and physical systems; the underlying emotions bubbling around. If you haven’t got anything physical, it’s very hard for a GP to deal with you.’ (homeopath)

(*ibid*: 46)

The enhancing of and boosting of homeopathy was further argued by defining the differences between conventional medical approaches. The description below demonstrates the demarcation between conventional medicine and homeopathy by portraying the action of homeopathy as potentially therapeutic. A homeopath claims:

‘We have opposing principles. For instance, eczema is a kind of catarrh of the skin and must be driven out not pushed inwards. Steroid creams push inwards, homeopathic ones outwards.’ (homeopath)

(*ibid*: 47)

The notion of homeopathy as an alternative and a way of boosting the credibility of homeopathy were combined in a description by one homeopath who claimed:

‘Well, homeopathy probably offers the largest threat as GPs see it, as being the alternative to what they do, some feel guilty if they know it works, train for 8 years and think they can practice but they haven’t a clue. The most unethical thing a practitioner can do is to try to practice both. They work in the opposite ways.’ (homeopath)

(*ibid*: 47)

By highlighting the role of the alternative practitioner, these claims bolster the demarcation between conventional and homeopathic practice. Significantly, the above claims are all potential complaints in which conventional medicine does not attract merit.

In the second theme, identified under the heading *Professionalizing alternative practice*, a homeopath described regulatory control of practice as achievable if homeopaths align with the concepts and ways of approaching illness adopted by conventional medicine. However, there is clearly concern that the autonomy and identity of homeopathy—and indeed the homeopath as an alternative—could be lost. One homeopath argues:

‘The problem is, if we are integrated, would we be controlled by the BMA and influenced by pharmaceutical firms?...It’s a good thing as long as you don’t get a power struggle with one trying to dominate the other.’ (homeopath)

(*ibid*: 52)

By aligning with and relating to the medical profession, the homeopaths claim that they could not manage and maintain their position as credible alternative practitioners. Another homeopath argued that GPs who mix and align homeopathic practice with medicine engage in an unacceptable practice, claiming:

‘GPs who practice homeopathy and allopathy together - to me it’s the ultimate sacrilege...Now you tell me that’s doing the best for patients...they’re in an indoctrinal situation - nine weeks or whatever it is now. It’s very difficult for them to change - you can’t mix the two.’

(*ibid*: 47)

A downside of the Cant and Calnan study is that the population was inconclusive—if the findings were taken to represent a wider population—and ultimately too ambitious to draw tangible conclusions from in relation to CAM in generalised terms. In treating the views held by the various practitioners, the study demonstrated insurmountable limitations when attempting to examine CAM as a complete phenomenon. In addition, the findings added to the confusion over what each discipline has to offer if they are all considered under the CAM umbrella. In so doing, the study did highlight the contested and controversial complexities in clarifying the role of particular therapies and differences between other practices and other therapies, bringing to the fore questions of credibility, acceptance and practicalities in viewing all CAM therapies as homogeneous.

Whilst recognising the need to promote professional credibility and status, the homeopaths did not see their practice as a challenge to the dominance of orthodox medicine. At no point did any of the practitioners question the status of orthodox medicine. Rather, homeopathy was viewed as a comfortable piece of the jigsaw situated within the existing framework of orthodox approaches.

This study is useful for the strategies identified by homeopathic practitioners in the pursuit of autonomy from orthodox medicine. In identifying two themes, Cant and Calnan argue that homeopaths adopt strategies that determine homeopathy as subordinate to medicine. In the first theme, *The position and the role of 'alternative' medical practice*, homeopaths viewed homeopathy as secondary to orthodox medicine. Homeopathy is portrayed as an alternative and 'last-resort' type of practice oriented to after disappointment with mainstream medicine. The homeopaths boosted the credibility of homeopathy by describing it as a holistic approach that is concerned with the complete well-being of the patient. A further separation from orthodox

medicine is made by describing the anticipated therapeutic action of homeopathy as opposite to conventional medicine.

In the second theme, *Professionalizing alternative practice*, the homeopaths described alignment with conventional medicine as a strategy for gaining acceptance within the wider medical field. Despite the identification of this strategy, homeopaths claimed that adopting orthodox practices was unacceptable, which positioned them as alternative on this basis. The homeopaths envisaged that practising on equal terms with orthodox physicians would result in discarding the image of the autonomous practitioner. The study was not explored from the position of the patients' situation, but was one of the more progressive recommendations for future research.

2.1.7 Homeopathy *Still* a Marginalised Field

In a topical qualitative study by Degele (2005), she argues that findings indicate that homeopathy has neither the institutional backing nor the theoretical persuasiveness to challenge scientific standards, which she claims leads to demarcation and a potential and continuing marginalisation from mainstream acceptance. In the study, Degele conducted thirty-five semi-structured interviews with both non-medically qualified practising homeopaths and orthodox physicians within the homeopathic community. The ratio of non-medically qualified to orthodox physicians is not stated, and Degele does not clarify whether or not non-medical and medical homeopaths view homeopathy differently. There were thirty-five participants in the total sample. The participants were asked to describe their views of homeopathy. As a way of forming their views, the participants spontaneously contrasted homeopathy with approaches used in orthodox medicine.

The main area of enquiry was how to understand the practice of homeopathy, to identify how homeopathy is different from orthodox medicine, and how it gains acceptance. However, Degele noted that in taking this approach homeopathy becomes demarcated from orthodox medicine and remains marginalised. As way of collecting the data, Degele (2005) enquired:

Do homeopaths accept the claim that it is up to the outsiders to demonstrate how their doctrine fits in with and conforms to scientific norms? Or do they develop and defend alternative models of science?

(ibid: 113)

Analysis of the data was carried out by applying the principles of constructivist grounded theory identified by Strauss and Corbin (1994). By applying a constructivist grounded theoretical approach, Degele portrays the findings as accurate representations of events. In so doing, she identified two main strategies that, she argues, are produced for gaining scientific acceptance, and at the same time have a potentially adverse effect that works to separate homeopathy from orthodox medicine— and thus leaves homeopathy as a deviant form of scientific practice on the perimeter of the medical mainstream.

The first strategy cited by Degele, termed ‘adaptation’, is identified by the way that homeopathic practitioners learn, adapt, and align their practice with the rules of orthodox medicine. Degele argues that institutions like the pharmaceutical companies directly influence everyday homeopathic practice. Therefore, by adapting to the rules of clinical effectiveness in a medical paradigm, homeopathy can gain a limited scientific acceptance within the orthodox field. However, there is a level of non-acceptance regarding homeopathic practice in relation to credibility, proof of plausibility and effectiveness.

As a result, homeopathy is positioned as an anti-paradigm, due to the lack of infrastructure and financial backing. Practitioners are interested in scientific studies as a way to boost the credibility of homeopathy with the aim of getting recognition for funding and in gaining social acceptance. The main target is health policy, by pressurising the appropriate institutions and gaining positive media approval. The cost of this approach is described as avoiding the notion of homeopathy as an alternative medicine and merging concepts with orthodoxy to gain mainstream approval. As a result, Degele states that homeopathy is portrayed as on the margins of the medical market, lacking in credibility and being drawn into using medical jargon and concepts for acceptance and thus, paradoxically, sitting uncomfortably within medical theories in order to find a degree of acceptance.

Furthermore, a second strategy highlighted by Degele is the development of the ‘alternative setting’—that is, the way that practitioners categorised themselves as belonging to a specific counter-cultural group. The main tenets are identified through the division of everyday practice and the adoption of either pseudo or scientific standards. The downside is that there is a split between two groups of practitioners: one group characterised as a deviant alternative and the other viewed as assimilated into the mainstream medical system. Furthermore, the notion of the ‘alternative setting’ is broadly defined by describing the system of homeopathy in therapeutic terms—that is, homeopathy being defined through medicines that reputedly act in an unscientific manner and with an opposite mechanism to that of orthodox medicine.

In an attempt to gain acceptance for the homeopathic community, the two strategies ‘adaptation’ and ‘alternative setting’ work to separate homeopathy from orthodox medicine by making relevant differentiation a significant issue. Degele argues that although homeopathy has adopted aspects of scientific research, in doing

so the roots of the homeopathic approach have been distorted. Therefore, when compared with the medical orthodoxy, homeopathic practitioners are viewed as alternative deviants who do not have the infrastructure to organise themselves appropriately. The findings show that homeopathic practice has little to no effect on medical science and research, yet conventional medicine forces homeopathic practices to make statements on adaptation or deviation that present homeopathy as a potentially marginalised field positioned in a culture of scepticism.

This useful study informs how practitioners in their everyday homeopathic practice view their practices. By identifying broad strategies, Degele provides an intriguing understanding of how homeopathy is positioned when contrasted with orthodox medical practices – that is, either by adaptation or deviation in the form of an alternative practice. Regardless if this criticism is generalised or not over a broader arena of homeopathic practice, it offers a perspective from which to explore homeopathic practice further at both a micro and macro level.

Where Degele differs significantly from this present study is that she certainly identified that homeopathy is separated from mainstream medicine, but at no time does she question the status and power associations that orthodox medical practices have. Instead, Degele accepts its dominance and its use as a yardstick against which to measure homeopathy. I question the rationale behind this, in that Degele has neglected to examine an integral issue—the presence of credibility and status issues that lead to homeopathy’s continuing marginalisation from mainstream acceptance. I explicate this effect in my findings.

Second, the views that Degele offers as evidence are specifically from a practitioners’ data set. She does not consider their patients or the consultation process. This limits her potential findings. Third, Degele does not examine the finely grained

interactive processes—the social or sequential organisation of talk and subsequent discourses—that work to continually marginalise homeopathy from mainstream acceptance, and which may provide a framework for a solution. Fourth, Degele recognises the potential downside of contrasting homeopathy with orthodox medicine, but does not offer any challenges, potential solutions or future avenues for research.

An implication for this thesis is that it should consider the strategies proposed by Degele, to examine whether or not they are salient to both homeopathic practitioners and ‘homeopathic’ patients, or either group. Degele’s study contributes to a gap in the research that could be explored further regarding everyday homeopathic practice viewed as a contested and controversial knowledge claim located in a culture of scepticism.

2.1 Discussion

To summarise the argument so far, I have identified and shown that the social actors within the homeopathic community on some level are aware of credibility, status issues and the line of demarcation between homeopathy and mainstream medical practices, which I argue in effect leads to marginalisation from mainstream acceptance.

First, I highlighted potential difficulties in sourcing quality work within the field of CAM, and particularly homeopathy. I described publication bias in the indexing of relevant literature and how I overcame such issues by searching widely on a variety of databases not solely concerned with CAM. In addition, I was not looking for studies that showed positive results commonly associated with traditional and positive approaches to research. Rather, I searched for qualitative work that identified

strategies that worked to set apart homeopathy and ultimately contribute to its marginal location.

Second, I reviewed previous qualitative studies, which I can draw on to substantially improve the trustworthiness of the present study's findings and the implications for the thesis. I achieve this by showing how the strategies and themes adopted by participants highlight credibility concerns, presenting homeopathy as a contested and controversial practice.

Third, in so doing, the findings show that from a socio-political perspective homeopathy has neither the institutional background nor the theoretical persuasion to make an impact on the wider medical market.

Chapter 3

Homeopathy as Discourse(s)

In this chapter, I identify the research gap, explaining how a discourse analytical perspective on homeopathy benefits in contrast to other forms of qualitative data analysis. Within all the studies reviewed to this point, the data collected is assumed to represent stable and consistent underlying positions. Thus, no study has investigated the construction of homeopathy derived from practitioners, their patients, and homeopathic consultations. Therefore, I identify and fill a gap in the literature

3.1 Discourse Analysis as an Appropriate Method for this Study

The strength of applying DA, in comparison to other forms of qualitative data analysis, is that the talk and discourse itself is the phenomenon under investigation. Attributional inferences from this theoretical stance are not seen as stable expressions of casual thinking but are worked-up in interaction to manage such inferences like justification, criticism, accountability, and so forth. In traditional forms of research, social language use is given little attention beyond treating it as a research tool for data collection purposes (Jeffery 1979). On the face of it, the above studies fail to take into account the everyday social practices that demonstrate how homeopathic practice is negotiated, resisted and sustained as a potentially marginal form of medical practice.

3.1.1 Homeopathy as Discourse(s): A Re-reading of the Commonsense Assumptions

The potential of discourse analysis then focuses on the talk and the discourse in play of a minority group, namely the social actors in the homeopathic community—moreover, offering the potential to explicate how the participants reproduce broad discourses that assist in sustaining their subordination to notions of mainstream medicine. In identifying discursive strategies from the talk and subsequent discourses that the participants orient to, mobilise and make relevant in mutually intelligible interactional contexts, DA offers ways to challenge existing practice with the aim of explicating such practice and suggesting innovative ways forward by focusing on the functional properties of language use.

Therefore, DA is the most appropriate method of analysis for this study because, by applying a discursive perspective to homeopathy, it produces a re-reading of common assumptions and verbal strategies taking place in social interaction (reference). Therefore, the effect of discourse analysis research in homeopathy reveals multiple versions of the phenomenon produced by the people who choose to advocate, practice, and look to practice such a treatment. DA has revealed a range of tacit discursive skills and communicative practices that people can draw on when talking about contested or controversial issues such as homeopathic practice (Edwards and Potter 1992; 1993; Potter 1996; 1996a; Wooffitt 1992).

The concern is that an in-depth focus is maintained on the participants' intelligible, interactive accounting activities and how participants address and negotiate the wider cultural scepticism about homeopathic practice. Hence, a discursive perspective focuses on the participants' constructions of homeopathy, and

how these constructions are accomplished and undermined in ‘institutional’ research interviews and in the spontaneous setting of the homeopathic consultation. Thereupon, by a detailed analysis of participants’ everyday social practices through talk and discourses, I can explicate how homeopathic practice comes to be positioned on the margins of mainstream acceptance. For instance, the data collected at the site of the research interview and homeopathic consultation (‘naturally occurring’, verbal encounter) can provide such a resource, where people in their talk get things done *in situ* and perform specific social functions. In contrast to traditional approaches, views provided in interviews or consultations are treated as a neutral pathway to an underlying reality or, as Potter (1996a) calls it, ‘out-there-ness’. Discourse analysts contend that DA explicates how participants’ descriptions function within the particular contexts in which they are provided with specific effects (Edwards and Potter 1992; Wetherell 1998).

The key area of the research interview and the homeopathic consultation is an important site of social interaction where everyday homeopathic practice is rendered meaningful. It is in such everyday contexts that homeopathy is not received passively, but negotiated, resisted and interpreted into the practitioners’ and their patients’ practices. As a topic of study, this discursive space is currently under-represented in previous studies. Significantly, Ainsworth-Vaugh (1998), Stiles (1996) and Yardley (1996) argue that the medical encounter is primarily the site where the practitioner and patient co-construct an illness characterisation; inequalities are constructed, made factual and justified in everyday talk, and presented over broader discourses. In this present study, I aim to contribute concrete evidence to an understanding of the credibility issues and marginalised perspectives of homeopathy under construction. I shall explicate the ways in which participants continually displaying the contested,

new and controversial properties of their practices when making claims in a mainstream medical/homeopathy dyad.

3.2 Discussion

I have now identified the research gap in which DA can be appropriately applied. It is important to pay attention to and demonstrate the strengths of applying DA compared with other forms of qualitative data analysis. As discussed, I argue for discourse analysis as the most appropriate method for this present study by showing how, when applied to participants' talk about homeopathy, it offers a re-reading of the common assumptions and strategies taking place in social interaction. Moreover, it shows how, in understanding homeopathic practice and their expectations of it as a form of treatment, the participants' tacit communicative resources are deployed to accomplish interpersonal activities relevant to the interactional business at hand. Concurrently, I aim to identify the re-occurring discursive patterns that participants use to get thing 'done' in interaction.

This brings the ongoing argument to chapter. 4. Here I have tried to provide various insights for a specific theoretical and methodological approach informed and influenced by discursive procedures and approaches embedded in a primarily innovative discourse analytical framework (Wetherell 1998; Edwards and Potter 1992) that emphasises and is dedicated to the merits of discourse analysis—applied to the empirical data.

Chapter 4

Methodology

In this chapter, I argue that participants' homeopathic practises can be examined by applying DA, which offers an alternative approach to traditional research methodologies.

First, in order to examine how participants talk about homeopathy I adopt a DA framework. This particular approach has a well-established history in ethnomethodology and conversation analysis (CA), combined with post-structuralism. I explain how ethnomethodology, CA and the broader discourses informed by post-structuralism are concerned with context on the interactional level where social actions are accomplishments and the wider discursive effects of the discourse is in play. Second, I critically review previous discursively informed studies that have been applied in analogous contentious and controversial contexts and evaluate their potential contribution to this present study. I examine the benefits of analysing competent language use and how applying DA can lead to original and important findings regarding talk about homeopathy.

Third, in a detailed examination I will argue for the use and merits of adopting aspects of Wetherell's (1998) theoretical framework to the analysis of discourses and Edwards and Potter's (1992) method of analysis for talk, accounts and discourses in this present study.

Finally, I discuss the novel types of data derived from a wide range of contexts: the researcher in research interviews with practitioners and their patients, and homeopathic consultations between practitioners and patients. I close this chapter by asking a main research question followed by three sub-questions of the data.

4.1 Methodological Influences: Immediate Contextual Effects

Here I illustrate the theoretical and methodological influences that inform in a relatively unusual combination as a way of approaching data analysis. A significant role is played by Garfinkel (1967), who developed and defined ethnomethodology, which argues for the explication of intersubjective social accomplishments. That is, ethnomethodology takes on board the members' mutually intelligible methods of socio-cultural shared understandings used to accomplish sensitively structured and mutually understandable social actions. However, while in close parallel with the verbal interactive analysis similar to the turns of talk in CA, it is primarily oriented with the analysis of the mundane and institutional discursive accomplishments of social actions made *in situ*. From this perspective, social actors produce texts that are imbued with culturally shared expectations and understandings as a way of being considered as skilled members of a particular cultural community. Below I show three relevant aspects informed by ethnomethodology that directly define context at the

local level within this present study, namely, indexicality, reflexivity, and the documentary method of interpretation.

4.1.1 Indexicality of Interaction

The notion of indexicality brings attention to the word or description being indexical, which is described as the sense people make out of an utterance and subsequent social action by relating it to the precise context in which it occurs. In other words, they index the details of the exchange to a specific and contingent situation relevant to members' intelligible accounting practices (Garfinkel 1967).

Indexicality makes sense of the uniqueness of any interactive activity or event, and draws our consideration to the ways in which one accomplishes properties of practical action. There is a similarity here with CA, which principally focuses on interaction in using the turn-by-turn, sequential organisation of talk. CA has provided a useful source for the analytic portrayal of context and the context-specific elements of social action. At this micro level social action and social facts are simultaneously context-shaped and context-renewing; a speaker's utterance is constructed and designed with regard to the immediate preceding and following interpersonal social actions (Heritage 1984).

The indexical qualities allow descriptions to be used in a flexible manner and over interaction. The multiple combinations within the construction of an utterance are primarily sense-making discursive devices. In addition, the immediately previous actions inevitably add to the framework in terms of which the next action will be understood. Accordingly, the research process, rather than explaining the meaning of a particular utterance, can analyse the actions for the participant's response to the

understanding of the others during verbal interaction. There is a focus on the strategic use of language. Descriptions accomplish specific discursive business; utilising a precise complex organisation of sequential turns which do centralize on pre-planning or strategies but on contingency and the expertise of a competent speaker, flexibly and continually (re)produced by the social actor (Garfinkel 1967; Heritage 1984).

4.1.2 Reflexivity across Data Sets

Indexicality and reflexivity are closely linked and are concerned with the immediate continuous recognition of the construction of sense-making over interaction. In this context, an event or the self becomes an object after one has given it a definition. This notion of reflexivity suggests that descriptions are not merely about or representing something; they are also *doing* something. They are part of being implicated in a practical activity. Descriptions are not used simply for their own sake but are part of an indexical interactive sequence.

When a description is recognised and occasioned then it becomes part of a practical enduring social action. The focus is on the inferences and attributions of the actions they perform. Descriptions are never viewed as a neutral telling of the facts. On the contrary, they are constructed to counteract activities such as justifications or criticisms (Edwards and Potter 1992). Suffice to say, formulations and their inferences, then, are not neutral theoretical outlines but concise context-specific consequences inter-related to future actions. Thus the inferences made are based on intelligible, culturally shared taken-for-granted understandings, expectations and norms of the phenomena being discussed.

4.1.3 Documentary Method of Interpretation

Within ethnomethodology, a further notion in the reworking of description and facticity is the documentary method of interpretation. The methodology initially consists of viewing how factual evidence is constituted drawn from a social experience and that the facts appear to cohere to a specific pattern. If a pattern is identified then the pattern is utilised to act as a model for producing results in new facts that are gathered within another situation.

To demonstrate this hypothesis, Garfinkel (1967) carried out a potentially controversial experiment with students, explaining to them that he was developing a new form of psychotherapy. The students talked about their personal problems with an anonymous therapist, who was behind a screen, via a telecom system. They were subsequently asked to question the therapist, in which he or she could only answer, yes or no. The students were unaware that the answers were random and not authentic, but the findings showed that they were intelligible to the students and there was a pattern to the advice received. The point was that the students attempted to make sense out of a social order that was indeed senseless. In doing so, they relied on their mutual collectively shared normative expectations and intelligible understandings of the experimental situation.

The focus is on the capacity to produce order out of the information made available, so there can be no accurate truth claims—only subjective notions. It showed a way to evaluate how people create their own social sense meaning and relate it to specific contexts within their talk and out of the information provided. Moreover, the answers from the therapist in the experiment made sense only in the context of the experiment and not beyond, suggesting that the students relied on their intelligible

culturally shared expectations and understanding to present as competent participants of the study.

For example, take the normative principles deployed in the ending sequence of a homeopathic consultation (Example 1). In this sequence, the speakers PP (the patient), DH (the practitioner) and MP, (PP's husband) check and agree to the closing of a verbal interaction. This is achieved by a number of explicit actions, demonstrating the 'indexical', 'reflexive' and 'documentary method of interpretation' sense-making qualities of mutually intelligible social actions *in situ*, as I argued above. Moreover, the participants are observed to be relying on the normative nature of a closing sequence during a medical encounter.

Example 1

265 PP: thank you very much =
266 DH: well(.) I do hope it goes well and (.) thank you
267 very much let me know
268 PP: = thank you (.) thank you very much =
269 DH: = what happens (.) alright (.) lovely look after
270 yourself
271 MP: thanks =
272 DH: = bye

Thus, based on the ethnomethodology principles Example 1 demonstrates, the objective order of social interaction is ongoing, accomplished through the practical and concerted social actions of the participants themselves. There is a continuous momentary production maintaining order in the social interaction. By adopting indexicality, reflexivity and the documentary method of interpretation, a sense of structure emerges as a practical accomplishment of everyday communicative and interpretive processes.

4.2 Conversation Analysis

The analyses of everyday language use reflecting MP3 or audio recordings from real life social interaction. CA approaches argue that details such as intonation and phrasing are made relevant to assist in the action that is being performed. In contrast, language has commonly been viewed as a reflection of precise meaning, paying specific attention to truth claims and arranged into neat categories and categorisations (Schegloff 1991; 1997).

However, CA principally focuses on interaction in using the turn-by-turn, sequential organisation of talk that has incorporated many of the theoretical links to ethnomethodology demonstrated above. That is, CA focuses on social actions that are produced in talk and inherent to the organisation of conversations by adopting the indexical, reflexive and documentary method of interpretation points made relevant by ethnomethodology above.

The rhetoric that Schegloff (1997; 2007) uses describes CA as ‘talk-in-interaction’, which is observed as a highly structured domain of social activity in its own right. The objective of analysis is not to begin with a list of pre-established and theory-led questions or concepts to be explored. CA, then, does not approach the data seeking broad societal differences—for example, medical or non-medical homeopaths and how they might define themselves and their experiences. Rather, the focus is on investigating the participants’ fine grain orientations, acknowledging the indexical, reflexive and sequential organisation of talk as well as their word selection. In other words, it is time-honoured not to impose the analyst’s interests and perspective on the research data and processes being made relevant.

Schegloff (1997) argues that the proximate context—which includes the features of talk such as the genre (in this study the research interview or the homeopathic consultation) and the sequences of talk as it happens in the interaction—is the focus for discourse analysis. The distal context—the site, social class and cultural setting—is viewed as irrelevant unless it is made relevant in the interaction through the conversation activities. The study of micro-conversational patterns then allows one to describe contextual variation, exploring the structural organisation of talk and showing how speakers manage verbal interactive sequences and the internal design of talk-in-interaction accomplishments.

4.2.1 Conversation Analysis Assumptions

CA has three main assumptions. The first is the structure of institutional and mundane talk in which talk reveals certain structures orientated to by speakers. It is important to note that the structures are independent to the psychological motivations of the speaker. The second assumption is sequential organisation, which takes into account how utterances cohere and the context shape of the speaker's action is made conditionally relevant—that is, reference to context being addressed in terms of the preceding sequence of talk. The context of a following action is contingently formulated with every present action performed. In the last assumption, the empirical grounding of analysis is recognising the first two assumptions within a fine grain analysis of transcription of talk (Atkinson and Heritage 1984).

Consequently, CA is described as data driven drawing primarily from talk directly recorded during an interaction sequence. The focus is on the specific action of the empirical conduct of the speaker (Widdicombe and Wooffitt 1995). These are the

essential elements to the context specifics found in CA. What is more, Schegloff (1992) addresses what is pertinent within interaction by introducing the notion of relevance and procedural consequentiality. First, in considering relevance there are numerous ways in which to describe the event, the self and significant others. CA needs to demonstrate how the speaker orients to the current description. Second, procedural consequentiality highlights that it is not sufficient just to demonstrate that the description is relevant to the interaction. Rather, a CA perspective enquires: (i) How does talk in, for example, a homeopathic consultation account for the social action being performed—its shape, content and character? (ii) What are the fundamental design features of an utterance oriented to during the interaction? (iii) How does the participants' tacit understanding of or orientation to the normative underpinning demonstrably inform their interpersonal conduct? (Wooffitt 1992, 2001). Third, the context of such interaction must be co-constructed, constituted and accomplished in interaction by each speaker to maintain the orderly, intelligible talk. The researcher cannot take for granted that the speakers are within the constraints of the institutional context throughout an interaction because the external setting is a hospital or a school. This must be demonstrated in the course of the context of the talk and reviewed as locally produced from moment-to-moment.

Moreover, a CA view addresses how description is treated in the utterance by the speakers and not in truth claims of the formulation. The analyses in CA leads one to review conversational sequences in which descriptions are examined for the various performances that descriptions are components of, and how they are adapted or are challenged over the duration of an interaction, and where a speaker displays their understanding of what has preceded—through a series of turns which cohere and relate to preceding organisational sequences (Schegloff, 2007). The fundamental

claim in comparison to analysing from a wider critical discursive analytical standpoint is that there are no ideological assumptions in CA that precludes displaying what is happening in the interaction by reference to the participants' orientations. These key assumptions in relation to language use, influenced by ethnomethodology and conversation analysis, are micro sites in which specific interpersonal business is accomplished. However partial Schegloff (2007) tries to characterise the technical application of CA by explaining:

... the focus of this organisation is not, in general, convergence on some *topic* being talked *about*, but the contingent development of *courses of action*. The coherence which is involved is that which relates the action or actions which get enacted in or by an utterance to the ones which have preceded and the ones which may follow. The very root of the word "interaction" underscores the centrality of the action to the commerce between people dealing with each other, and this aspect of their conduct is a central preoccupation informing what people do in the turns in which they speak, and informing as well what they heard to be doing.

(*ibid*: 251, *original emphasis*)

The CA approach to data in this study was helpful in explicating the patterns and ways in which the participants in question–answer sequences engaged in various interactional and inferential activities to maintain the normativity, contextual expectations and understandings in their discursive work and procedures to construct factual accounts as action orientation productions.

Although context is a participants' orientation, all discursive procedures and implications have the potential to be investigated for a wider socio-political, historical and cultural grounding from a DA perspective.

4.3 Discourses in Context

In a contrasting theoretical frame, Wetherell (1998) argues for a genealogical context to identify that not all utterances are simply locally produced participants' orientations, but rather include a social, historical, political and cultural context. More than this, Wetherell claims that the distal context—including social class, institutions where the discourse occurs, ethnic groups and cultural settings—should be explored in tandem with the proximate context.

That is, considering context from the broad perspective of the discourse, Foucault (1980)—who informed Laclau and Mouffe (1987) and Shapiro's (1992) work—as a post-structuralist theorist has notions of power centred on discourses as a system of representation. Language is constructed through a number of discourses and any meaning of a word is dependent on the use of the discourse. From this perspective, the discourses of power and knowledge are an inseparable whole. The focus of attention is the rules and practices that produced meaningful statements and regulated discourse in different historical periods. Language and practice are constructed and viewed as discourses in the same way that the subject or object is co-constructed and constituted through discourse. In this context, discourse is a group of statements that provide a language for talking about a particular topic at a particular historical moment. I will return to the Wetherell (1998) analytical framework in more detail to outline the theoretical format I used for this thesis.

4.3.1 Genealogy

This particular analytical framework is influenced and inspired by Foucault's (1970; 1973, 1980) notion of genealogy as a methodological approach. It should be noted that Foucault's notion is used to analyse discourse that reveals power and knowledge processes, with an emphasis on bodily practices of the prison and hospital/medical practices (objectifying) and discourses of sexuality (subjectifying)—focusing on concepts and the particular relationships between discourse/power/knowledge. The aim is to uncover the object through the discourse, which is defined by the processes and an articulation of history resulting in the history of the present. Foucault argues that the routine everyday practices and decision-making processes of modern institutions define one's role through current discursive practices, for example in the way in which medical practices are produced, constructed and sustained as a fundamental truth claim. As demonstrated in this study, participants were shown to question this particular system by opting for homeopathy as an alternative to mainstream medical theories and practices. In so doing, the participants defined their practice by contrasting with notions of mainstream medical practices. For Foucault, power is not viewed as a central force but rather as a multi-layered and a multi-faceted network functioning at numerous different levels. Foucault argues that analysis should investigate broader discursive patterns within much larger contexts and explicate the subtle societal processes in play.

4.3.2 The Object Constituted

Informed by Foucauldian thought, Laclau and Mouffe (1987) argue that social relations are established within a system of relations with the object constituted in specific and available discourses. They ask what meaning and use the word has in specific discursive contexts, stating:

... the classical distinction is between semantics – dealing with the meaning of words; syntactics – dealing with word order and its consequences for meaning; and pragmatics – dealing with the way a word is actually used in certain speech contexts.

(ibid: 83)

Laclau and Mouffe argue that the meaning of a word is context-specific and forms part of pragmatics, but both semantics and pragmatics are interdependent, as the discursive object is constituted in the context of an action orientation. Therefore, the interpretation or meaning of a word is context-dependent at various levels.

4.3.3 Social Structure in Discourse

Moreover, from this perspective the notion of social structure is built from discourses constructed through history (Burman and Parker 1993; Foucault 1970, 1980; Mouffe 1992; Parker 1992). Therefore, discourses provide positions from which to speak, invoking that everyday mundanely accepted discourse is organised around dilemmas and prevalent throughout various views, for example when descriptions of holistic treatment of the person-centred genre contrast with the reductionist symptom–disease-orientated approach of mainstream medicine. This can create a tension resulting in a competing problem, but there must be ways in which the participants resolve this in the discourse. The task of the analyst is to demonstrate

the discourses in use, the themes and the power relations within them and the consequences for the person(s) or group member in terms of the opportunities that are possible or unavailable to them (Burr 1995).

4.4 Discourse as Part of Analysis: The Influence of Discourse Analysis

The term ‘discourse’ is informed by Gilbert and Mulkay (1984) and defined in social psychology by Potter and Wetherell (1987) as a broad perspective:

... to cover all forms of spoken interaction, formal and informal, and written texts of all kinds. So when we talk of ‘discourse analysis’ we mean analysis of any of these form of discourse.

(*ibid*: 7)

By focusing on discursive procedures, the term ‘discourse analysis’ is described by Potter and Wetherell (1987) as having three fundamental areas of focus, as follows: (1) to establish a method for the study of social texts; (2) to provide an explanation of how to proceed with the research, and; (3) to demonstrate how people’s accounts can be considered through the empirical study of language as social texts *per se*.

4.4.1 The Interpretative Repertoire

In addition, a body of work adopting a discourse analytic framework has drawn upon ethnomethodologically informed approaches that embrace the concept of the interpretative repertoire (Edley 2001; Edley and Wetherell 1997; Potter and Wetherell, 1987, Seymour-Smith *et al* 2002). The original concept of repertoire, or

more precisely linguistic repertoires, was developed by Gilbert and Mulkay (1984) in a study exploring the sociology of scientific knowledge, in which two contrasting repertoires were identified. The formal contexts of the conventional view of science were constituted through the use of the *empiricist repertoire*, and the informal biographical or personal features of scientific activities were constituted through the *contingent repertoire*.

Moreover, interpretative repertoire is a used system of terms, it will often organise around metaphors and figures of speech common to the particular community that it is involved. As a range of discursive resources, it is commonly an easily identified argument, description and assessment constructed with familiar clichés, anecdotes and tropes (Potter and Wetherell, 1987). Moreover, Edley (2001) suggests that in this context the interpretative repertoire is viewed as “part and parcel of any community’s common sense, providing a basis for shared social understanding” of the given topic and a kind of resource or yardstick of words for people to use on their own terms and in their own contexts (*op. cit.*: 189). In addition, Potter and Wetherell (1987) argue that there is a co-operatively joint social consensus to interpretative repertoires and the flexible mobilisation of them in verbal interaction.

Consequently, studies by Edley (2001), Edley and Wetherell (1997) and Seymour-Smith *et al* (2002) maintain that discourse, when analysed in the form of the interpretative repertoire, is highly variable and accords to the current rhetorical demands of the immediate context. With the focus on language, it is suggested that indeed there are certain ways of talking that construct specific interpretative repertoires already provided to one by history. The discursive strategies identified in this present study are representative of the interpretative repertoire in the way the discursive strategy operates as a resource and adopts many of the features of mutually

intelligible culturally shared resources in relation to the discourses in play concerned with homeopathic practice.

4.4.2 Action Orientation of the Competent Language User

However, it was Potter and Wetherell (1987), in the context of social psychology, who suggested the *three* main tenets of discourse analysis as function, construction and variation. In so doing, they postulate language in this context as produced in action-orientated sequences but, more importantly, it can be analysed for the function, construction and variability elements. The focus of attention is on how people use language to make requests, apportion blame, defend and so forth by providing explanations through the identification of the function of the discursive resources made available. From this perspective, language is explored as a process of active construction and not limited as a representation or description of a topic commonly found in traditional forms of research. Accordingly, over the course of an interaction there will be variability and contradiction. Potter and Wetherell (1987) illustrate the type of phenomena a discourse analyst is interested in with the aim:

...to show how social texts do not merely *reflect* or *mirror* objects, events and categories pre-existing in the social and natural world. Rather, they actively *construct* a version of those things. They do not just describe things; they *do* things. And being active, they have social and political implications.

(*ibid*: 6)

Therefore, the identification of these kinds of patterns and features of language use is the analysts' task. Potter and Wetherell (1987) compared analysing discourse to a craft skill such as riding a bicycle. The 'doing' of the process cannot be easily

explained. Rather it is the application of a synthesis of theoretical perspectives highly influenced by the constructionist genre. It becomes easier to understand if analysing discourse is considered in contrast to a randomised controlled experimental research design, where the method is neatly contained and explainable in a step-by-step process. Although not proposing definitive answers, the authors outline the theoretical implications:

There is no analytical method, at least as this term is understood elsewhere in social psychology. Rather, there is a broad theoretical framework, which focuses attention on the constructive and functional dimensions of discourse, coupled with the reader's skill in identifying significant patterns of consistency and variation.

(ibid: 169)

The method here is not simply a staged process that clips together and forms concrete organisational features. In many academic institutions, one is encouraged to read to get the gist, while in DA terms the essential task is to read and re-read the texts and, in the search for patterns and reoccurring discursive configurations, to be aware of contradictions and vagueness throughout. A key part of the analytical approach is to identify such subtleties and explicate the 'doing' of the process.

4.4.3 The Discursive Action Model

Considering these points, an approach called discursive psychology developed by deploying what was known as the discursive action model (DAM) (Edwards and Potter (1992). Its aim is to analyse constructions of mental states as social action and the inferences and interpersonal function made available. The DAM was inspired by the philosophy of Wittgenstein (1953), Austin's (1962) speech act theory and

theoretical and methodological concerns of ethnomethodology and conversation analysis (Edwards 2007). Edwards and Potter (1992) characterise it thus:

We are not merely looking at the speaker's cognitive models, or understandings of the world or of himself. And certainly, it is difficult to accept any suggestion that these categorizations are unconscious or automatic indications of underlying cognitions. The study of real talk, of what words *do*, encourages a much more active, constructive notion of the relation between words and what they describe. Categorisations also enter into the DAM in the area of fact construction: this relies on the fact that some features of social categories relate to people's supposed knowledge, experience or skills: scientists may know about experiments, policewoman know about rape and so on.

(*ibid*: 176)

Thus, the DAM treats talk and discourse as social (inter)action, in contrast to the fixed isolated entity as considered in mainstream psychology. I shall return to the DAM later when I outline my method of data analysis to the mutually intelligible accounting practices made relevant through analytical inferences that serve the attributional business oriented to by the participants.

4.5 Participant's Category

Finally, an aspect of analysis largely inspired by CA is the notion of category as a participant's resource (Edwards 1991). To date, categories within psychological research have represented the natural cognitive processes underlying categorisation and that they are enduring performed entities (Edwards 1991; Horton-Salway 2001; 2001a). In contrast, in a study by Widdicombe and Wooffitt (1995) the term 'category' in a discursive psychology context is a linguistically orientated social construction that is drawn upon in talk and subsequently represents particular ways of ordering the social world. Therefore, categories applied to particular social contexts have possible connotations relevant to wider historically influenced social practices.

Widdicombe and Wooffitt (1995)—largely inspired by Sacks (1992; 1972)—argue that category membership is a flexible discursively accomplishment that is co-authored and articulated by the speaker, who orientates to and constructs the sense of category as they speak. This has similarities to the ways that homeopathic practitioners and their patients' accounts are moulded in discourse(s) that draw upon the linguistic resources available to either group to formulate specific categories and categorisations. Unwittingly, categories are more than a set of labels that allow one to infer a system of behaviours or interpretations about people. Rather:

Categories, then, are 'inference rich': and participants in interaction display their orientation to the kinds of inferences which may warrantably draw about them by virtue of their membership of categories.

(Widdicombe and Wooffitt, 1995:70)

Therefore, people in particular categories are usually seen to know things or have assured epistemological skills. Thus, categories are associated with category predicates, with category-bound activities that members are expected to orient to. For example, the Membership Category Device (MCD) is a commonsense version for a class of people: for example, 'gender' contains such categories as 'man' or 'woman'. In discursive psychology, these resources can be analysed as a participant's category, invoking a range of inferences in terms of knowledge, rights and normativity of events. Once again, categories are viewed as a negotiated achievement (Edwards 1991). Widdicombe and Wooffitt (1995) suggest that every category is imbued with cultural significance, which will serve a specific purpose either with a potentially negative or positive action:

All of these are membership categories: they are culturally available resources in our language for the identification and description of persons, which allow us to make reference to other people and ourselves.

(ibid: 69)

The precise meaning and action is part of reflexivity and indexicality, but the point is to demonstrate that a category is a social construct ‘building-block’ being mobilised for moment-to-moment sense-making activities (Edwards 1991). The concept behind indexicality brings attention to the word or description being ‘indexical’, which is described as the sense people make out of an utterance or particular action by relating it to the context in which it occurs. Indexicality makes sense of the distinctiveness of any interactive activity or event, and draws our consideration *vis-à-vis* the ways in which one accomplishes properties of practical social action.

Moreover, binary oppositions within categories lend themselves to the situated work of making comparisons and contrasts; thus, demonstrating that the many contingent versions of the social world have evidently been constructed in talk and have a variety of inferential and organisation properties throughout accounts (Edwards 1991; Edwards and Potter 1992; Widdicombe and Wooffitt 1995; Sacks 1992, 1972) observed across the data sets in this present study.

4.6 Interest for the Discourse Analyst

In taking all of the above theoretical and methodological perspectives into account, Potter (2004) then explains that the type of phenomena a discourse analyst is interested in as:

Discourse as *texts and talk in social practices*. That is, the focus is not on language as an abstract entity...Instead, it is the medium for interaction; analysis of discourse becomes, then, analysis of what people do.

(*ibid*: 203, *original emphasis*)

4.7 Discursive Studies in Analogous Contested and Controversial Contexts

As a way of applying the above perspective, I shall now introduce three studies informed by discursive approaches, procedures and perspectives in analogous contested and controversial contexts that apply the various theoretical and methodological perspectives discussed above. The approaches proposed contrast with homeopathy constructed as representative of accurate events, as discussed in the previous qualitative studies examined in Chapter 2. The defining principle of a discursive psychology perspective that applies the method of discourse analysis is to look at action: what people do with their utterances, how people construct accounts in a way that makes them appear authentic, and factual discursive accomplishments. The focus of attention is on how people use talk to defend, make requests, justify, criticise and so forth, and with what effects. Focusing on the verbal organisation of talk and the broader social, historical and cultural contexts within discursive methodology, analysis of discourse offers ways to redefine the taken-for-granted assumptions made in mundane and institutional contexts (Edwards and Potter 1992; Wetherell 1998).

4.7.1 Managing the Contentious Illness Narrative

First, a useful study that demonstrated a ‘bottom-up’ discursive psychological approach is the analysis of Myalgic Encephalomyelitis (ME) or Chronic Fatigue Syndrome (CFS). ME is generally constructed similarly to a physical disease, where versions are used to counteract accounts of psychological vulnerability or malingering (Horton-Salway 2001). Here, however, ME or CFS is viewed in the context of an illness narrative taken from a research interview with a married couple. The analysis explicates specifically how a sufferer, Angela, and her partner, Joe, construct and make sense of ME as a practical experience, and how the inferences made are described as part of a blaming or defensive orientation (Edwards and Potter 1992; Potter and Wetherell 1987). Therefore, discursive situated social actions become relevant since this method is adopted for investigating everyday casual attribution. Attributions from this view are not seen as stable expressions of casual thinking but are worked up in interaction (Edwards and Potter 1992, 1993; Potter 1996a; Potter and Wetherell 1987).

Angela and Joe’s story is constructed through multiple discourses that are momentarily positioned in scene setting, corroborative evidence, and before-and-after sequences. The goal was not to discover if the narratives were accurate descriptions but to analyse the discursive strategies and discursive devices used by Angela and Joe to make their account seem factual and solid, and to analyse how they counteracted competing discourses. The analytical framework focused on the rhetorical and interactive contexts of the sufferers’ accounts.

The findings show that language use as a form of social action contrasts with an accurate representational system. Moreover, the descriptions made were never

neutral but performed specific actions. Angela positioned herself as being genuinely physically ill to avoid the stigma of suffering from a psychological disorder and the potential connotations that may go with this latter description. In so doing, Angela and Joe addressed issues of personal accountability by countering potential accusations of malingering or psychological vulnerability by proportioning blame for catching ME to an enterovirus contracted in the water at a swimming pool. Subsequently, an emphasis on the occasioned and situated nature of interaction became the area of focus as the couple's discursive resources, which were made available, reflect commonsense notions in relation to the topic of ME or CFS. Demonstrated from an intersubjective perspective, accounts are the products of co-constructed actions during the organisation of verbal interaction (Horton-Salway 2001).

With a wider reference to the notion of socially constructed descriptions, Horton-Salway (2001) argues that these descriptions are actively and continually made, depending on the discursive resources available. This contrasts with a fixed property of views defined in traditional research. In this way, Horton-Salway offers a useful insight into participants' interactional concerns by piecing together discursively orientated attributional theories about the cause of ME or CFC, where people relate causal explanations to everyday experiences. Horton-Salway thus demonstrates how descriptions are worked up and portrayed as factual.

This study offers a way to approach the potentially contentious topic of homeopathy by examining accounts as action-orientated. In a similar way to the analysis of ME or CFS by Horton-Salway (2001; 2001a), through the participants' accounts the topic of homeopathy becomes relevant through activity sequences and worked up as factual. By applying a DA framework to homeopathic practice,

homeopathy is merely seen as a social practice in activity sequences constructed by the speakers themselves during an exchange. Discourse viewed as action-orientated offers a detailed explication of how homeopathy comes to be marginal in terms of mainstream acceptance.

4.7.2 Talk about Contested Environmentally Sustainable Conduct

Second, one way in which environmental discourse was examined was by exploring the ways in which talk as social action may work to contribute to or undermine the adoption of more environmentally sustainable conduct (Kurz *et al* 2005). That study is useful to inform this present study in the way that the authors identify both the interactive properties (informed by discursive psychology) and wider discursive strategies in which the participants construct their actions (informed by Foucauldian forms of discourse analysis) either as having a minimal or unavoidable effect on the environment.

Data was collected through open-ended interviews with nine participants who previously participated in a field experiment concerned with the promotion of water and energy conservation within the home. The interviews focused loosely on probes in relation to the importance residents placed on issues of water and energy conservation. All interviews were taped and analysed orthographically, with the transcripts examined for recurring tropes and contradictions in the participants' accounts.

The method of analysis reflected the position of Wetherell (1998) and Rapley (2004), who advocate the relative merits drawn from discursive psychology (DP) developed by Potter and Wetherell (1987), Edwards and Potter (1992), Potter (1996),

Edwards (1997), and Foucauldian forms of discourse analysis (FDA) developed by Parker (1992) respectively, since ‘both approaches are concerned with the socially constituted nature of reality and the way that this reality is constituted in talk within particular social contexts’ (Kurtz *et al* 2005:605). The analytical position here is viewed as a synthetic and eclectic approach driven by the research question. The two approaches proposed in DP and FDA are merged to produce a rich set of understandings at various levels, including the level of practice. The analysis focuses on two fronts: the participants’ own stake in environmental issues (DP); the ways in which practices are enabled through broad discursive strategies (FDA). The discursive strategies worked to discount responsibility for negative environment impacts. The analysis was conducted with a pro-conservation agenda on behalf of the authors (Kurtz *et al* 2005).

The findings showed that, through talk about consumption and conservation of water and energy, particular discursive strategies were mobilised to account for and legitimise specific resource-consumption practices. Water was constructed as a finite, precious and shared resource that must not be wasted. Energy in contrast was constructed as replaceable and essential for life rather than something that must not be wasted. Furthermore, the self was constructed in binary oppositions, such as a conserver of resources and waster of resources. The authors Kurtz *et al* (2005:616) thus viewed themselves in the role of ‘custodians of the earth’s natural resources’.

The interactive perspective informed by DP offered the residents the positioning of the other being responsible for the wasting of resources, while positioning the self as merely the user of resources, which can be viewed as potential barriers to change. The ‘I’ use and ‘I’ waste device contrast could be drawn upon with the potential implications for justifying material practices. Therefore, by applying

both a micro (discursive psychologically informed) and macro (Foucauldian informed discourse analysis) level of analysis, the commonly occurring discursive devices identified, together with the wider notion of discourse and subsequent discursive strategies, are argued as resources the participants have available that justify their practices.

This study usefully informs the present study in the way that Kurtz *et al* embraces two analytical perspectives, offering a broad analysis of the data. In doing so I can adopt the notion of strategies identifying how homeopathy is oriented to acceptances—a situated sense-making practice—and also identify and explicate how and what is achieved by illustrating the discursive resources and discursive devices used by participants to justify their practices.

4.7.3 Attending to Credibility in Accounts of the Paranormal

Finally, with a focus on interaction and the finely grained sequential features of talk, I cite Wooffitt (1992), who conducted a CA-informed study where he recorded accounts of paranormal experiences. The potentially controversial perspectives on authentic paranormal experiences have parallels with homeopathy's position as a pseudo science in the sense that both subjects fail to produce reliable and replicable scientific evidence.

The data was collected from interviews from three main sources, namely the University of York College and an advert placed in local newspapers in York and Bristol. The theoretical sample consisted of students, local and national UFO research groups, professional mediums, and potential witnesses who claim to have paranormal experiences.

On a methodological level, arguably, a potential difficulty with CA is that the broader social issues are not addressed, as it is an inherently locally produced analysis. In addition, Wooffitt shows that speakers attend to normative expectations regarding what kinds of utterances are appropriate responses to previous turns. For instance, those questions are expected to be followed by answers and so forth. Therefore, utterances are oriented to by previous utterances; speakers continuously react to previous statements and the inferences that they make available. This approach takes into account that talk is sequential, acknowledging that conversations are organised on a turn-by-turn basis (Wooffitt 1992).

However, Wooffitt revealed some recurrent features of the ways that speakers warrant and build up authenticity, factuality and credibility within potentially contentious descriptions regarding supernatural experiences. Wooffitt argues that speakers who claim to have experienced aspects of supernatural phenomena position themselves in a potentially unfavourable and vulnerable light, open to challenge based on issues of credibility. As a way to counter this, speakers attempt to portray the normality and ordinariness of the descriptions through everyday and unexceptional events. To achieve this, Wooffitt argues, the specific design of the descriptive sequences provides a factual representation of the social organisation of everyday interaction.

In identifying this, Wooffitt's aim is to investigate and explicate the tacit use of the communicative resources available. In so doing, his findings show a selection of discursive devices whereby the factual status of reported events is accomplished. By drawing on various discursive devices and adopting contrasting structures, speakers work up their accounts as factual through persuasiveness as a social action,

which is produced in a range of discursive contexts that serve to emphasise the strangeness of the situation.

The Wooffitt study offers a detailed analysis of mundane social practices by speakers who claim to have experiences of a controversial, contested and supernatural nature. Moreover, demonstrating how the range of inferences is made relevant works to offer an understanding of the cultural and interpersonal consequences of paranormal experiences and the relationship between culture and the individual. What Wooffitt's study offers to this present study of homeopathy is insight into the ways accounts are designed to do things such as defend practice by working up the inferences to warrant the objectivity and factual status of the descriptions in the face of the adversary. Moreover, in reacting to each other's turns, participants inevitably display their interpretations and understandings of those statements in their own turns, which can be accepted or rejected in the next turn. Speakers' continuous display of their understandings reflects the principle that analysis should be driven by participants' interpretations and concerns, as displayed in their utterances, rather than by the analyst's theoretical concepts and interests. Hence, my analysis was not led by my prior theoretical assumptions about homeopathic practices.

In line with the studies above, taking a discursively informed approach to the data in this present study of homeopathic practice is not to construct it as a finished or complete object. Rather, homeopathic practice is portrayed as a discursive, ongoing, socially performed project. I shall now discuss the specifics of the analytical framework and method of analysis applied to this present study.

4.8 Discursive Analytical Framework Used in this Present Study

In this present study, I draw from a combination of the two theoretical perspectives discussed earlier, that is, the ‘bottom up’ and ‘top down’ approach to analysis—the communicative competences and question–response organisation of participants’ talk about homeopathy, and addressing the broader effect of the discourse in play. The present study is not concerned solely with the methods identified by Burman and Parker (1993), Edwards and Potter (1992), Foucault (1970; 1973; 1980), Parker (1992; 2003), Potter and Wetherell (1987), or Schegloff (1997), but rather with what Wetherell (1998) calls a ‘synthetic’ framework for analysis. This form of DA merges a range of influences drawing from the ‘bottom up’ approach, where attention focuses on the features of action orientation of talk informed by the performative qualities (informed by Austin (1962)) of situated social practice—sometimes referred to as talk-in-interaction or conversation analysis (Hutchby and Wooffitt 1998; Schegloff 1997; Wooffitt 1992)—synthesised with a ‘top down’ perspective that focuses on the notion of power and wider ideological practices (Holloway 1989; Parker 1992, 2003; Burman and Parker 1993), with analysis focused on the broader socio-political, historical and cultural contexts (Foucault 1970; 1973; 1980) defined in post-structuralism.

Within this framework, the analytical method is generally referred to as ‘perspectives in discursive psychology’ (Edwards and Potter 1992). Here, the style of DA is informed by perspectives in an ethnomethodology and a CA frame engaged with post-structuralism, offering a combined form of DA (Derrida 1976; Edwards and Potter 1992; Garfinkel 1967; Foucault 1980; Laclau and Mouffe 1985, 1987; Shapiro 1992; Wetherell 1998).

In particular, Wetherell's (1998) critique and conclusions regarding CA and DA were appropriate, as I was not interested solely in the fine-grain mutually intelligible interactional features of talk in 'question-response' sequences, which is advocated by ethnomethodology/CA, but also in the broader culturally shared socio-political, historical resources made available through participants' communicative strategies and the wider effect of the discourses in play. Thus, when examining homeopathic practice from a DA perspective, I set out to explicate how participants perform specific actions and how these actions function within the particular context in which they are provided. In addition, the findings provided information regarding the broader discursive strategies informed by post-structuralism (Foucault 1980).

Wetherell's (1998) approach to DA shall now, I contend, highlight the merits of such a perspective. To begin, Wetherell considers Schegloff's (1997) comments on critical discourse analysis (CDA), in which Schegloff posits that analysis should be fundamentally grounded in the fundamental turn-taking principles of CA. From this perspective, it is suggested that CA offers a frame to confront the 'intellectual hegemony' imposed by CDA, whilst simultaneously offering a method as well as an interpretation (Wetherell 1998:388).

Consequently, Wetherell takes on board Schegloff's proposals by arguing that CA does indeed offer a useful approach to DA, but maintains that the discipline needs to be broader. Firstly, CA does not offer an explanation of 'why this utterance here?', 'what is this participant doing?' and 'with what effects?' in a broader context—discussed above—and secondly, a fuller analysis must be broader than merely Schegloff's technical discipline. In citing 'why this utterance here?', 'what is this participant doing?' and 'with what effects?' Wetherell (1998:403) critiques the method of CA as inhibiting the analyst from taking account the broader socio-

political, historical and cultural context in which specific segments of talk occur. In so doing, Wetherell argues for a more integrated approach that reviews Schegloff's take on CA and incorporates some post-structural perspectives whilst working with two contrasting analytical frames. Wetherell claims that combining post-structuralism and CA informed practices and procedures would offer a fuller integrated approach.

However, Schegloff claims that post-structuralism views status and power in interaction on a loose or ungrounded basis that may misinterpret the object. Given that there are numerous possible perspectives on what happened and what is relevant for the participants during interaction, from this point Schegloff's analysis is fundamentally known as strict talk-in-interaction, with its own distinguishable framework. Schegloff claims that CA studies categorically show that speakers attend to normative expectations regarding what kind of utterances are appropriate responses to previous turns and what is being 'done' in interaction.

4.8.1 Foucault's Post-Structuralism

However, it is important to consider again Wetherell's (1998) analytical frame, influenced by Foucault's (1970; 1973; 1980) genealogy. Undoubtedly, it's very much in contrast to Schegloff's form of talk-in-interaction. Here, Foucault's theory of making discourse *per se* is the topic in question.

As discussed briefly above, Foucault's focus draws on post-structuralist perspectives of discourse⁹ by highlighting the de-centred object and subject which subsequently influenced Laclau and Mouffe's (1985; 1987) and Shapiro's (1992) position. From this perspective, discourse is socially, politically, historically and

⁹ Here I refer to Foucault's later works (1970; 1973; 1980) i.e. *Madness and Civilisation: A History of Insanity in the Age of Reason* (1961) was still structuralism as demonstrated by Derrida (2001) in *Writing and Difference*.

culturally situated, and brings objects and the subject into seemingly tangible entities. The subject or object is viewed as constructed and influenced by the historically situated ideologies and the person is thus not the author of his or her own discursive activity. Rather, society constitutes and reads the subject. Consequently, meaning is never fixed; it is continually in flux and is precarious. The notion of the object, experience or event can never be confined in a single closed description. This argument then constructs the objects and subsequent accounts—mobilised categories and descriptions produced through multiple discourses—as contingently and momentarily positioned productions (Laclau and Mouffe 1987; Potter 1996a).

Crucially, to understand the themes of construction one must distinguish the relevant discourses that are made available during the situated exchange. The themes identified by the participants are determined by the discourse as a consequence of the current interaction, emphasising the highly occasioned, reflexive and indexical qualities of the objects and positions made available through discourse.

The crux of the argument is that Wetherell proposes to draw theoretical and methodological principles from both post-structuralist accounts of the constituted object and subject within an ethno-methodology/CA fundamental framework. Equally, Wetherell draws upon Shapiro's (1992) notion of genealogical historical relations to power and Laclau and Mouffe's (1985) notion of the 'argumentative texture of social life', which is an activity of making intelligible meanings from continually developing social patterns and goes beyond Schegloff's indistinguishable boundaries fixed around CA. In developing these points, Wetherell draws from analytical concepts of variability and argumentative threads, taking on a more integrated and synthesised stance than a segregated CA or solely post-structuralist perspective involving the societal organisation of the broader discourse.

By adopting and applying this approach, Wetherell maintains that if one simply follows Schegloff's approach one cannot break away from the theorist's categories, as it is the analyst who is drawn to one particular part of the conversation rather than another. However, Schegloff argues that the data is sufficiently analysed when the principal conversational sequences are exhibited and explained. In contrast, Wetherell states that it is imperative to map the socio-political, historical and cultural 'argumentative threads' of the broader discursive patterns, identifying members' intelligible sense-making in various depths—thus, examining the mutually culturally shared meanings and expectations that speakers rely on when producing intelligible conversations and performing social actions *in situ*.

She then summarises a range of complexities and issues relevant to the participants of this study during analysis of social phenomena:

An adequate analysis would also trace through the argumentative threads displayed in the participants' orientations and would interrogate the content or the nature of members' methods for sense-making in more depth.

(Wetherell 1998:404)

The emphasis is on the contingent, occasioned and situated nature of interaction by giving some insight into the local formulations and the broader discursive resources made available, oriented to through discursive strategies.

4.8.2 Summary of the Analytical Framework

In summary, the innovative analytical framework that I use for this study is advocated by Wetherell, and focuses on the participants' orientations within an integrated DA framework. I am concerned with the indexical, reflexive and normative

qualities of talk *in situ* and the negotiation of occasioned categories, discursive practices and procedures within a broader genealogical context. That is, the investigation should incorporate the socio-political, historical, and cultural influences and contexts in discourse. This can be extremely revealing in terms of the formation of the discursive strategies made available through both the examination of the mutually intelligible communicative competences of talk and the wider societal effects of discourses *per se* (Wetherell 1998).

4.9 Method of Analysis: Applying the Discursive Action Model (DAM)

As a way of adapting Wetherell's (1998) analytical framework to this present study, I incorporate the post-structuralist notion of the constituted discourse applying the poststructuralist notion of discourse as a system of statements which constructs the object and integrate to this an analytical method to the participants' talk, discourse and accounts proposed by Edwards and Potter (1992)—known as the discursive action model (DAM).

It is concerned with how participants rationalise and draw towards favoured orientations over others and asks 'What are the implications when events are put into activity sequences of language?' This fundamentally demonstrates the constructive question–answer sequences and action performance of descriptions found in participants' accounts. When these accounts are constructed in talk and texts, they are examined for their discursive action and how aspects of language are used to perform specific actions. Edwards and Potter (1992) explain:

In everyday life, these discursive actions do not occur in isolation but as part of activity sequences. Typically, such sequences involve interpersonal or intergroup issues involving blame, responsibility, reward, compliment, invitation and so on.

(op. cit: 156)

Examining participants' talk and subsequent discourses in this way can broaden the perspective of the social activities in which social action, descriptions and attributions are produced. It explores the way that social actions and procedures are constituted within discursive acts. A broad theoretical framework, with reference to the structures of discourse, its construction, function and variation during social interaction, is, then, the way to approach analysis.

The defining principle is to look at social action: what people do with their utterances and how people construct accounts in a way that makes them appear solid and factual. More than this: in their accounts, people customarily attend to issues of agency and personal accountability as a discursive practice and how people accomplish the action of defence, criticism or justification by focusing on the discursive devices and discursive approach and procedures used (Edwards and Potter, 1992).

4.9.1 Central Features of the DAM

One of the central characteristics of the DAM is its focus on action rather than cognition, examining formulations and the inferences people make available in talk. The focus is to examine specific features of the data, asking: 'why this utterance here?', 'what is this participant doing?' and 'with what effects?' In the first phase I carried out an examination of the discursive resources for patterns of both consistency and variability and the social action being performed through the interactive organisational properties of their talk – that is, the identification of features shared by members' intelligible accounting practices and the diversity in the content or form of the subsequent texts. Significantly, reportings are situated in activity sequences. For

example, patients through defensive orientations of their practice, were observed to criticise the failure of conventional medicine as a basis for looking to homeopathy, which presented homeopathy as a potential ‘last-resort-form’ and ‘type’ of practice. These kinds of discursive patterns, accounts, formulations, versions and so forth are examined for the inferences and assisted in identifying consistency in the different social constructions participants used and their purpose (Edwards and Potter 1992).

4.9.2 Building up the Facticity of Accounts

In the second phase of analysis I applied the following feature of the DAM known as ‘fact and interest’: how people manage the dilemma of stake and interest in their own accounts and talk up their experiences as authentic, solid and factual and their practice as credible by deploying a variety of discursive devices such as stake inoculation, category entitlements, category membership, ontological gerrymandering (Potter 1996a), contrasts, systematic vagueness, vivid description, narrative, (Edwards and Potter 1992), extreme-case formulations (Pomerantz 1986), consensus, consensus and corroboration (Horton-Salway 2001), three-part lists, (Jefferson 1990), footing, (Goffman 1986) active voicing (Wooffitt 1992), the formulation ‘At first I thought ... (mundane X), but then I realised...’ (extraordinary Y), (Jefferson 1984; Wooffitt 1992), ‘troubles telling’ talk sequences (Jefferson 1984a; Jefferson and Lee 1992), and ‘doing being ordinary’ (Sacks 1992; Stokoe and Hepburn 2005) which can be situated against actual or possible different versions and explanations. Edwards and Potter (1992) posit that the way an account is constituted serves a specific rhetorical function. Therefore, the focus of analysis is on the action-orientation of accounts and on the ways that one accomplishes fact construction through activities such as

defences, criticisms or other nuances. Participants' descriptions were rhetorically organised and situated in activity sequences to serve specific functions, such as managing the interpersonal issue of personal credibility—primarily through defensive orientations.

The participants' descriptions were examined for their wider effects. I arranged the effects from the accounts into broad discursive strategies, whilst focusing on how the situated sense-making interactional business was being attended to and how the speakers demonstrated their orientation to this business, and what strategies and procedures seemed to inform their orientations. In addition, when considering the broader social notions the discursive strategies are viewed as positioning homeopathic practice as a contested knowledge claim situated in a contrast structure or binary opposition to notions of mainstream medicine.

4.9.4 Personal Accountability

The final phase of analysis features the DAM in terms of how people attend to the notion of agency and personal accountability as a discursive practice. People attend to personal accountability within the reported event: that is, whether the report of the event was based on a testimony of a reliable witness or presented as a mundane discussion of some potentially controversial matter. Therefore, accounts can be examined to see how people accomplish the action of defence of their practice. If the account is motivated by self-interest then the veracity of the account will be undermined. Speakers orient and attend to accountability during the construction of accounts as an interpersonal issue. From this context, Edwards and Potter (1992) identify accountability as:

When people describe events, they attend to accountability. That is to say, they attend to events in terms of what is normal, expectable, and proper; they attend to their own responsibility in events and in the reporting of events.

(ibid: 7)

The analytical task is to explore the way in which accountability is a discursive accomplishment and how it is defended in specific contexts. Thus, when participants construct versions of prior experience, events, people, and places and so forth, they attend to the responsibility and accountability for the content of their accounts. The focus is on the way different kinds of discursive activities pose different sorts of accountability issues concerning claims to factuality and authenticity. A feature of such accounting is to construct an ‘out-there-ness’ world (Potter 1996) in contrast to a subjective mirror of their own desires and agendas concurrently incorporating both in Phase One and Two of the DAM. Therefore, participants adopt a variety of discursive devices and strategies to constitute their accounts as objective and factual. If the account is motivated by self-interest then the veracity of the account will be undermined. The discursive devices deployed by the participants are therefore examined for issues pertinent to accountability such as how they attend to and manage their own individual personal credibility as an interpersonal issue.

4.9.5 The Process of the DAM

The three analytical phases of the DAM were carried out recursively in contrast to sequentially. During this process, I revisited the data time and time again, contrasting and comparing the data, considering the broader post-structuralist ‘top down’ patterns of similarity and variance and the local functions that they served. The

participants' accounts and versions in the context of homeopathic practice revealed unique and common broad discursive strategies in the production and sustainability of multiple descriptions aimed at situating homeopathic practice as a contested and potentially controversial form of treatment on the fringe of the mainstream medical market.

4.10 The Research Questions

From a DA perspective, the main research question and the three sub-questions in this present study inquire and aim to answer:

How do participants construct, negotiate, (re)-produce and sustain their homeopathic practices and with what discursive effects?

The large bulk of homeopathic literature and the initial analysis suggested that homeopathic practice is infused with legitimising, credibility and status issues. Therefore, three sub-questions emerged from the data sets:

Sub-Questions:

- i) How do homeopathic practitioners attend to the issue of personal credibility and make orientations towards the contested aspects of their practice?
- ii) How do homeopathic patients attend to the issue of personal credibility and make orientations towards the contested aspects of their practice?

iii) How do both practitioners and their patients in homeopathic consultations attend to and manage personal credibility of their contested individual practices?

Chapter 5

Research Design

In this chapter, I describe the research design for undertaking a discourse analytical study by explaining the step-by-step process involved in the everyday practicalities of applying a discourse analysis framework. First, I highlight ethical procedures involved in setting-up such a study, followed by the kind of sample relevant to the study design. Second, I explain how I recruited the participants from three sources consisting of practitioners, their patients, and homeopathic consultations. All of which provide three original data sets. Third, I give the details and merits of carrying out a preliminary study.

5.1 Research Design Features

The study was based in Scotland. The data for the study was collected from three sources: a) twenty semi-structured research interviews with homeopathic practitioners; b) seventeen semi-structured research interviews with homeopathic patients; c) and five homeopathic consultations taking place between the above two groups—offering an original and unique research sample for a single study in the field of discursive psychology and homeopathy.

The use of the research interview to collect data from both homeopathic practitioners and their patients respectively is frequently adopted in qualitative inquiry and is particularly relevant to discursive psychology (Wetherell 2001; Wetherell *et al* 2001; 2001a; Wooffitt 2005; Yates 2004). I collected data in a total of thirty-seven

semi-structured face-to-face interviews and five homeopathic consultations recorded from the everyday work settings of practitioners, which provided a view of the mundane practice of homeopathy.

On commencement of this present study the guidelines in the Research Governance Framework—which set out standards for good practice—were followed, where the Department of Health (2001) focuses on the ethical concerns when involving human participants, stating that “the dignity, rights, safety and well-being of participants must be the primary consideration in any research study”. In carrying out any research study, the process raises ethical dilemmas, which I shall now discuss (Howarth and Kneafsey 2007a).

5.1.1 Ethical Considerations

Ethical decisions are ongoing and arise throughout the entire research process, from conceptualisation and design to the literature review, data analysis and the final report (Long and Johnson 2007; Mauthner *et al* 2005). The first stage in the setting up of this present study involved writing a research proposal in 2003 in accordance with the ongoing ethical procedure set out in the British Psychological Society (2000) Code of Conduct, Ethical Principles and Guidelines:

In all circumstances investigators must consider the ethical implications and psychological consequences for the participant in their research. The essential principle is that the investigation should be considered from the standpoint of all participants: foreseeable threats to their, psychological well being, health, values or dignity should be eliminated.

(ibid: 8)

To begin to reach an appropriate research design with which to address the ethical implications, I submitted a research proposal to the Queen Margaret University

College (QMUC) Research Degrees Committee for consideration. This was subsequently accepted on 7 July 2003. The second stage involved completing an application for ethical approval to the QMUC Research Ethics Committee. The recommendations suggested that I make an external application to the National Health Service (NHS) Multi-Centre Research Ethics Committee (MREC) before commencing data collection. I gained ethical approval for the study on 4 December 2003. Ethical procedures were developed in collaboration with MREC that satisfied their priorities and guidelines (MREC Response Form and Letter of Approval Document, Appendix, 1). This process provided the study with practical guidelines with which to commence. The MREC is informed about all developments of the study on an annual basis through a standard progress report form. From here, I could approach the research sample (Howarth and Kneafsey 2007).

5.1.2 Research Sample and Selection Criteria

In identifying a sample for the present study I opted for the ‘theoretical sampling’ technique, (treated as synonymous with a purposive sampling). Theoretical sampling is a method by which the researcher decides on the theme of the data and where to collect it (Kvale 1996). The subtleties of this sample population are set out by Mason (1996: 93-4), cited in Silverman (2002: 105):

‘Theoretical sampling means selecting groups or categories to study on the basis of their relevance to your research questions, your theoretical position ... and most importantly the explanation or account which you are developing. Theoretical sampling is concerned with constructing a sample ... which is meaningful theoretically, because it builds in certain characteristics or criteria...’

(ibid: 93-4)

From this perspective, theoretical sampling was the most appropriate method for the present study, since the criteria for participants involved experience of the homeopathic process. When concerned with practitioners, this involved membership of either the Society of Homeopathy or the Faculty of Homeopathy, experience of homeopathic case taking, prescribing a homeopathic medicine, and participating in a follow-up case with patients. In the context of patients, the homeopathic process consisted of having a homeopathic case history taken by a registered practitioner, followed by receiving a homeopathic prescription for a homeopathic medicine and participating in a follow-up consultation.

5.1.3 Sample Population

In total, the sample consisted of twenty homeopathic practitioners. Ten practitioners had clinical experience within the NHS and in the private sector and were affiliated with the Faculty of Homeopathy. The remaining ten were members of the Society of Homeopathy—to represent and locate homeopathic practice from theoretical, methodological and professional standpoints as discussed in chapter 1. The practitioners' years of experience ranged from five to thirty-six years, with an average of sixteen years. There were two male and eight female non-medically trained practitioners, and five male and five female medically trained practitioners.

Homeopathic patients were recruited from both medically trained homeopathic and non-medically trained homeopathic practitioners' clinics. In total, there were twenty-one patients. Patients' experience of using homeopathy varied from zero to sixteen years, with a median of six years. Of the patient sample group in the one-to-one interviews, thirteen were female and two male. Of the six patients participating in

five homeopathic consultations, there were five female and one male. Four out of the six participated solely in the homeopathic consultations; the remaining two patients participated in a research interview. One male patient participated in the role of accompanying his wife to the consultation, making the number total to six (see Table 1: Practitioners in one-to-one Interviews, Appendix 2; Table 2: Homeopathic Patient/Clients in one-to-one Interviews, Appendix 3; Table 3: Practitioners and Patient/Clients in one-to-one Homeopathic Consultations, Appendix 4). All the practitioners in the homeopathic consultations participated in the research interview. The number of participants varied from the originally anticipated number of participants. After identifying the sample, I could then proceed with informed consent, recruitment and data collection (Long 2007).

5.2 Recruiting of Participants

There were three main research contexts: interviews with practitioners; interviews with their patients; and the homeopathic consultation process between both groups. Each group recruited was interlinked in the informed consent, recruitment and data collection process. All participants for the study were recruited as a recursive process, which involved the practitioner taking an integral role as a gatekeeper (Millar and Bell 2005; Silverman 2002). I shall start by outlining the process of recruiting practitioners, followed by the participants for the consultation process, and finally describe how patients were recruited.

5.2.1 Recruitment of Practitioners

Prospective homeopathic practitioners were recruited through employing a range of strategies that were highly structured and involved precise organisation and negotiation skills. The first stage involved identifying potential participants. By studying homeopathic practice, and as a statutory registered practitioner, I knew of certain establishments that it might be appropriate to contact regarding the recruiting of participants.

Homeopathic practitioners were approached by randomly selecting private clinics listed in the *Yellow Pages* directory. From this perspective, I interpreted random selection by working in alphabetical order through the index of prospective participants. Additional practitioners were selected in a similar fashion through the Faculty of Homeopathy Membership directory. Again, I selected private establishments before approaching NHS clinics, the justification being that if I could reduce the amount of bureaucracy concerning the process of gaining access to NHS establishments for interviews, then that was the trajectory. Prospective practitioners were selected from within the Edinburgh and Glasgow geographical location due to cost and practicalities.

The prospective practitioners were written to in mid-December 2003, inviting them to participate in a research interview and/or a homeopathic consultation. I included within the correspondence an invitation letter to homeopathic practitioners and an advertisement for research (MREC Response Form and letter of Approval Document, Appendix 1).

Stated within the invitation letter, I invited practitioners to either agree or disagree to a homeopathic consultation being audio-taped and recordings being used

as research data. If both criteria were met, the practitioner were requested to assist as a gatekeeper in selecting and accessing appropriate patients for a homoeopathic consultation. The implication for the gatekeeper was their being qualified to work ethically and confidentially with the prospective patients (Miller and Bell 2005). The role of the gatekeepers was neither one of persuasion, nor was it of a coercive nature. Rather, in line with the theoretical sampling, this process of accessing and subsequent interviewing was realised through voluntary participation.

At the same time, I provided the practitioners with the relevant information when interested patients volunteered without coercion to participate in a research interview. Gaining valid informed consent from all prospective participants was the first and most important task. This is discussed below during the recruiting process and at the relevant points of collecting informed consent.

5.2.2 Selection Criteria

As a prerequisite for the selection criteria, all practitioners selected were either qualified doctors registered with the General Medical Council or homeopaths registered with the Society of Homeopathy. As registered practitioners, both groups are bound to a Professional Code of Ethics and to a Code of Professional Conduct regarding professional standards and guidance. As noted by the General Medical Council (2002), all doctors participating in research have a specific role and set of responsibilities:

Before starting any research you must ensure that ethical approval has been obtained from a properly constituted and relevant research ethics committee - such committees abide by the guidance for local and multi-centre research ethics committees, whether they are within the NHS, the university sector, the pharmaceutical industry, or elsewhere...You must conduct research in an ethical manner and one that accords with best practice.

(ibid: chapter 5)

Equally relevant is the Society of Homeopathy's Code of Ethics and Practice (2004) guidelines for practitioners concerning research and educational purposes:

Written consent shall be obtained in advance in making a video or other recording of a patient in consultation, or before producing in printed form any material from case notes, or likewise sending a communication electronically which may become printed matter...when obtaining consent, how material is to be used and with whom shall be made clear to the patient in order to define and restrict publication.

(ibid: 10-11)

In conducting the study appropriately, all practitioners were bound by their professional guidelines. All the practitioners adhered to a code of ethics when conducting research. In total, I wrote to thirty-five prospective participants in December 2003. By the end of January 2004, I received twenty-eight potentially positive responses from the clinics' secretaries. I followed this up by sending further information about the study. The information included a GP letter, a GP Information sheet, an Invitation Letter to the Homeopathic Practitioner, an Advertisement for Research, a Research Subject (Homeopathic Practitioner) Interview Schedule, a Research Consent and Confidentiality Statement, a Research Subject Information Sheet, and a Research Protocol in Lay Terms (MREC Response Form and Letter of Approval Document, Appendix 1), which covered all aspects of the study.

I started to receive correspondence from the middle of February 2004. Twenty-three of the twenty-eight practitioners agreed in principle to conduct a research interview, with fourteen agreeing to the homeopathic consultation. I wrote to the remaining five practitioners and invited them again to consider whether they were interested in participating in the study. I recruited another one and the remaining four did not respond. The twenty-four practitioners agreed that I could place an advertisement in their waiting room inviting patients to participate in a research

interview and/or homeopathic consultation, and leave relevant information with them to be distributed on request. (This point will be discussed further in the chapter under the heading patient recruitment.) I started to arrange dates for research interviews with practitioners between the months of March and June 2004.

In total, I received twenty-two appointments with practitioners for a research interview. I had one practitioner cancel the appointment and one who was unable to do the interview when I went to the clinic. In total, I collected twenty interviews. Of the twenty interviews, ten of the practitioners were General Medical Council registered doctors and ten Society of Homeopathy homeopathic practitioners. On audio-taping the interviews, one practitioner was not fully transcribed due to the poor quality of the recording— further details on the data collection method and duration of the interviews are discussed below. Before commencing the research interview with practitioners, I received a signed Research Consent and Confidentiality Statement and a signed Research Subject Information Sheet to verify that the relevant study information was read and understood (Long 2007). All participants were free to withdraw from the study at any time without prejudice.

5.2.3 Recruiting Participants for Homeopathic Consultations

Within this data collection period between March and June 2005, five practitioners stated that they had prospective patients who agreed—after reading the Advertisement for Research (Patients), Patient Letter, Research subject (Patient) interview Schedule, Research Consent and Confidentiality Statement, Information Sheet and Research Protocol in Lay Terms (Multi-Centre Research Ethics Committee

Response Form and Letter of Approval Document, Appendix, 1), which covered all aspects of the study—to be audio-taped during a homeopathic consultation.

The patients were subsequently invited to meet with me to further explain and answer queries regarding the study. I met with the prospective patients, where the study design and objectives were explained. I received a signed Research Consent and Confidentiality Statement and a signed Information Sheet from all participants before commencing data collection. The data collection process of audio-taping homeopathic consultations ran concurrently with the audio-taping of research interviews with practitioners and patients. I received all five audio-taped homeopathic consultations (the practicalities of setting up the audio equipment are discussed below).

As data, the homeopathic consultation proved difficult to accumulate. Its potentially sensitive nature and the practitioners' sense of discretion proved a delicate combination of factors when encountering the potential ethical dilemmas involved in the way participants can be recruited (Birch and Miller 2005). Patients had to volunteer to be involved and not coerced into participating. There was a relatively poor response in obtaining data from this site in comparison to the projected number. The duration of the consultations varied. One consultation lasted sixty-five minutes, three lasted ninety minutes, and the final one lasted fifty-five minutes (see Table 1: Practitioners in one-to-one Interviews, Appendix 2; Table 2: Homeopathic Patient/Clients in one-to-one Interviews, Appendix 3; Table 3: Practitioners and Patient/Clients in one-to-one Homeopathic Consultations, Appendix 4).

5.2.4 Recruiting Homeopathic Patients

To recruit patients, letters inviting participants to volunteer for the study were posted in practitioners' waiting rooms. As stated above, I wrote to practitioners in December 2003 to request the placing of an advertisement in their waiting room inviting patients to participate in the study (Barrett 2001). I provided the practitioners with the relevant documents, such as an Advertisement for Research (Patients), a Patient Letter, a Research Subject (Patient) Interview Schedule, a Research Consent and Confidentiality Statement, a Research Subject Information Sheet, and a Research Protocol in Lay Terms (see MREC Response Form and Letter of Approval Document, Appendix 1).

The advertisement for patients to participate in the study was placed in the twenty-two practitioners' waiting rooms between March and June 2004. There was a positive response from patients. In total seventeen patients volunteered to participate in a research interview. The practitioner who acted as a gatekeeper forwarded my name to the prospective participants. I arranged to meet with them on an individual basis to explain the study objectives, answer any queries, and collect the signed Research Consent and Confidentiality Statement and Research Subject Information Sheets before commencing data collection. Subsequently an interview room was set up in the clinics at the discretion of the practitioner.

5.3 Data Collection by Using Audio-Taping Equipment

The data collection method of the participants' research interviews and homeopathic consultations was by audio-taping, which produced written transcripts.

The procedure involved my setting up of the equipment in the everyday work setting of the practitioners' clinic. As stated above, all participants read and signed the Research Subject (patient) Interview Schedule, the Research Consent and Confidentiality Statement, and the Research Subject Information Sheet. They consented and agreed verbally to be tape-recorded before commencing. In the case of the homeopathic consultations, I had the equipment set up and left the practitioner and patient unobserved in the room. On completion of the consultation process, I returned to the room and switched the tape-recorder off. This approach to data collection contributed to capturing the naturally occurring notion whereby the collection process is as much as possible uninterrupted by the researcher (Griffin 2007; Potter and Hepburn 2007).

Modern, good quality recording equipment was required. An ultra-sensitive microphone that contained four micro-microphones incorporated within one compact unit was essential for clear good-quality recordings. A portable pocket-sized cassette recorder with mains and battery backup was sufficient in conjunction with this type of microphone.

5.3.1 The Semi-Structured Research Interview

As identified above, the data for the study was collected from three novel data sets derived from: a) interviews with homeopathic practitioners: b) interviews with patients; c) homeopathic consultations with the above two groups. As a participant in the semi-structured interview, I drew from experience carrying out interviews in a previous study for a Bachelor of Science (Hons) degree in homeopathy. I also adopted elements drawn from the homeopathic case-history process. Similar to the semi-

structured research interview, the approach to homeopathic case taking is a semi-structured and well-established social exchange where patients or clients generate discussion, negotiating their illness characterisation (Kaplan 2001). Arguably, the homeopathic case-taking process derives from various theories and methods primarily based on a therapeutic client-centred approach (Rogers 1983). This approach incorporates attributes associated with notions of congruence, empathy and unconditional positive regard.

However, in social psychology, particularly discursive psychology, the semi-structured approach to interview technique is slightly different. If one considers constructionist approaches to interviewing, then the interviewer and interviewee are viewed as co-constructing the contingent sense making. The interview site is regarded as a place of interest for how the data is constructed rather than an accurate representation of descriptions or facts. Therefore, by considering reflexivity, the researcher's influence on the data is of as much interest in the production of the final text as the interviewee's input. In line with this perspective, in this present study the aim of the research interview is to collect rich data by participating in the constructive process with the interviewees (Edwards 2003; Potter and Wetherell 1987).

In this present study, the aim of the research interview is to focus on what mundane talk achieves and how it is constructed, rather than as accurate description or truth claims. Therefore, consistency may suggest that the participants are drawing on a limited set of discursive resources available to them. The interview in discourse analytic research primarily focuses on variation in responses and not on merely looking for consistency as an objective of the analyst. Therefore, within the discourse, analytical paradigm interviews are slightly different from common notions of social research interviews. A range of discursive resources can be identified through the

analysis of the variation in the account. In the discourse analysis research interview, consistency is relevant but simply in the context of recognising patterns in language use (Potter and Wetherell 1987).

5.3.2 Research Interview Protocols

A separate research interview protocol was developed for use with both practitioners and patients/clients. Accordingly, analytical questions were derived by examining views, themes, and findings from previous homeopathic research and literature, identifying issues that merited further inquiry (Cant and Calnan 1991; Cant and Sharman, 1996; Degele 2005; Frank 2002; Swayne 1998; 2000). The prospective questions were based on homeopathic practices that previous research had explored and highlighted as relevant areas of inquiry through prior semi-structured interviewing technique.

The interview protocol for practitioners occupied broad sections under the headings of the practitioner, professional qualifications, homeopathy principles/mechanisms, homeopathic methods, treatment, consultation process, and patients. It was completed with a selection of questions inviting the participants to ask about and clarify any areas of ambiguity. In a similar way, the patients' interview protocol had a wide focus that was arranged into various themes intended to elicit an appropriate response and prompt topic-relevant responses (Smith 1995). The topics included examining patients' views about using homeopathy and about the practitioners, the consultation process, and their expectations of homeopathy as a treatment (see MREC Response Form and Letter of Approval Document, Appendix 1). Each practitioner interview lasted approximately sixty to ninety minutes in

duration, with patient interviews varying from sixty to seventy five minutes (see Table 1: Practitioners in one-to-one Interviews Appendix 2; Table 2: Homeopathic Patient/Clients in one-to-one Interviews, Appendix 3; Table 3: Practitioners and Patient/Clients in one-to-one Homeopathic Consultations, Appendix 4).

5.3.3 Analytical Questions

The theoretical framework I used to approach the semi-structured research interview allowed for a flexible structure mainly consisting of open-ended questions. The interview schedules with standardised questions characterised the conceptual intentions of the study. The questioning technique consisted of clarification and probing for in-depth details was developed depending on the participant's reply (Breakwell 2001; Silverman 1997, 2001, 2005). As suggested by Potter and Wetherell (1987) and Hepburn and Potter (2003), the research interview can be almost rhetorically challenging in order to elicit diverse responses from participants. By adopting this approach, I inevitably influenced the interactive process, eliciting diversity and degrees of variation in the response from participants. As an implication, the data generated proved rich and informative, offering a wide range of topics relevant to the participants' homeopathic practices. All participants were asked a similar set of questions from the interview schedule, thus affording a greater degree of comparison between responses. This made the task of coding and searching through the recordings for patterns and variations in response easier to manage. There were opportunities to elaborate on the sequence of questioning because the development of the discussion depended on the participant's response (see Protocol for Research Subject (Homeopathic Practitioner) Interview Schedule, Appendix 5; Protocol for

Research Subject (Patient/Client) Interview Schedule, Appendix 6). In so doing, the interaction can become closer to a representation of the contingently formulated everyday descriptions of homeopathic practices, with the premise that the analyst can access respective and reoccurring strategies within the phenomena (Denzin and Lincoln, 1994; Breakwell *et al* 2001).

5.4 Preliminary Study

Before conducting the main study, a preliminary investigation was carried out into the pilot interview schedules for both practitioners and patients. The requirement for this preliminary study consisted of asking the standardised questions from the interview schedules as part of question testing. I employed a question-testing method devised by Foddy (1995) to refine the interview schedules. In so doing, I identified potentially problematic aspects to questions, applied the double-interview technique, and finally asked the participants to think aloud so that I could develop my strategy for questioning them. Three research interviews were carried out with both practitioners and patients to identify whether the participants could interpret the questions as intended.

5.4.1 Participants and Recruitment

Recruitment for this preliminary study was combined with recruitment of practitioners and patients described above. Three participants from each research group attended the pilot interview.

5.4.2 Interview Protocols

All protocols were devised from the research interview schedules for the present study. The interview was carried out as indicated above by all participants, who were required to read and sign the Research Subject (Patient) Interview Schedule or the Research Subject (Homeopathic Practitioner) Interview Schedule, Research Consent and Confidentiality Statement, and Research Subject Information Sheet. They consented and agreed verbally to be tape-recorded before commencing.

The question-testing process involved asking about six to seven questions, while discussions with the participants clarified any issues that required attention. I used a notepad to write impressions regarding areas that could be developed or ways in which I could present the questions more clearly. During the first stage in the question-testing process I also noted where I had to repeat questions and where questions were misinterpreted or possibly difficult, and where the participants required more time to answer. Second, I applied the double-interview technique, where I probed for a clarification of the questions' main concepts by having the participant put the questions into their own words. Finally, by asking the participants to think aloud I could write notes on these impressions (Foddy 1995).

5.4.3 Analysis of Preliminary Findings

A selection of questions failed to work as they were intended. Concerning the practitioners' interview schedule, a question requiring them to define a symptom and the therapeutic process presented difficulties for two participants. They claimed it was an area requiring a significant response. However, if I gave more time for the

participant to answer, then a positive response was generated. All questions were subsequently kept in the interview schedule. The patients' interview schedules proved fruitful as well. I had to repeat a question regarding why they used a specific practitioner, and generally had to avoid using jargonised language when probing.

Questions identified as misinterpreted in the pilot study were kept in the present study's interview schedules. Over the three pilot interviews in each group, there was no consistency in identifying misinterpreted questions. At least one question per interview was misinterpreted. However, it did not reflect a significant pattern across the data. Again, there was no specific question that attracted little attention. What could be interpreted as a difficult question was generally attributed to the participants' hedged response. In this area, I gave more time for the participant to answer and, with prompting, generated a response. I could not define a specific question as consistently problematic from each of the interview schedules. By talking aloud, the participants demonstrated how they were building a response. This was useful to me to indicate where to probe for a more significant response.

Overall, the analysis showed that the present interview schedules generated a fruitful data set. In conducting the pilot, I attended to giving more time to the participants to answer the questions, which in turn provided a more flexible approach to question choice. If the participants gave a broader response, I could draw in suitable questions from the various sections in the interview schedule, rather than approach the research interview with a rigid question-answer type of interrogation predominantly found in a structured interview.

5.5 Data Analysis

I shall now outline how I conducted the data analysis process in this present study by discussing the transcription and the coding of the data.

5.5.1 Transcription

I started to transcribe the data at the same time that interviewing was taking place. The aim of transcription is to ascertain the theoretical academic goals and not simply to be a mundane, time-consuming chore. The data collected was transcribed between March 2004 and December 2004. The choice of transcription notation I adopted in this present study focuses on the participants' use of the discursive resources made available in the context of the analytical framework. In this present study, I was concerned with the sequential organisation of talk, the broad sense-making practices, and ways of accounting within this framework, which determined the level of transcription.

Therefore, all interviews and homeopathic consultations were transcribed using an abbreviated version of the full Gail Jefferson style (Atkinson and Heritage 1984). This method of transcription contrasts with the talk-in-interaction of conversation analysis, where the finely grained sequential features include a micro-pause, inflection on the vowel, overlaps, and so on. Since this present study did not require the depth of transcribing required for solely conversation analysis, a simplified version—Jefferson lite—was produced. (For a simplified version that reflects a transcript notation appropriate for this study, see Appendix 7.)

I carried out the bulk of transcribing. However, logistics determined this process itself to be problematic from a time-consumption perspective, and thus required the assistance of an experienced audio typist who was external to the project. Transcribing proved to be labour-intensive, each tape requiring anywhere between eight to ten hours or more of detailed work. I found it took sometimes the best part of fifteen hours to transcribe one interview. Acquiring an audio typist gave me time to complete other duties related to the study, such as reading up on the various perspectives to analysis.

All participants were offered a full transcription of the interview or consultation, to read and verify that they agreed to the content. Of the participants, one practitioner requested a tape-recording of the interview and homeopathic consultation; four practitioners requested a full transcription of the research interview. There were no requests from patients regarding transcriptions. However, on completion of the research all participants will receive a 1000-word executive summary of the research findings.

When consulting with the audio typist, close attention was paid to interpretative thinking and the ways in which I made sense of the data. The transcription method devised by Atkinson and Heritage (1984) and utilised by myself was replicated as feasible by the audio typist (Appendix 7). Therefore, research rigour, trustworthiness, and reliability of data were maintained as far as practically possible.

As a recursive process, the completed versions of transcribed text were compared with the tapes and any ambiguities were corrected, illustrating an extensive interpretative and analytical process. During this process of transcribing, I had the chance to undertake a superficial analysis – that is, to arrange the extracts into

strategies as part of coding. (For an example of a full transcript of a research interview with a practitioner, see Appendix 8.) An appropriate dissemination strategy of the research findings was outlined in the Research Subject Informed Consent and Confidentiality Statement and in the Research Protocol Explanation in ‘Lay’ Terms. Here, I stated that the information disclosed would be strictly confidential and that any material provided might be used in future publications, reports and/or articles but great care would be taken to ensure that the information is presented anonymously.

5.5.2 Coding

All three data sets, from practitioners, patients’ interviews, and everyday homeopathic consultations of varying sizes, were transcribed. The coding process allowed me to consider how the questions and the responses in the data would fit into the appropriate contexts within broad discursive strategies. This part of the process reflected a more comprehensive understanding of the actual data extracted from the completed transcripts. Various potential discursive strategies were developed and subsequently discarded. It was a recursive process of trial and error until broad discursive strategies were identified and emerged across the three data sets.

5.5.3 Coding Interviews

I coded the interviews provisionally, based on content or design of utterances with reference to the kinds of words, phrases or examples used or actions performed—namely, how participants enhanced the credibility of their individual practices through defensive orientations, contrasted with the notion of the medical

mainstream. The process involved exploring numerous extracts that initially appeared relevant and passages that were later omitted (Potter 1996a; 2004).

The interview schedules and protocols were the first main sources of the coding procedure. Overall, the process was recursive and, as strategies of interest and conflict began to develop, the data could be revisited. It also allowed me to gradually become acquainted with the data on a close analytical level. The initial interview and continuous re-reading of the data gave me the insight to identify the participants from the style of discursive resources drawn up. In the last data set, in the form of a homeopathic consultation, I got the opportunity to compare how the discursive practices and procedures were played out between both groups in the setting of the medical consultation.

I grouped together these codes in data sets, and subsequently performed a more detailed analysis within these sets. Coding files were formed and considered as chapters to be explored in the broader perspective of arranging the data in terms of discursive strategies and subsequently a thesis. Multiple descriptions of the participants' practices could still be drawn upon which revealed unique discursive strategies or reflected common discursive strategies relevant to each data set. All extracts that demonstrated binary opposition between conventional/mainstream/traditional medicine and homeopathy were considered initially useful. From these extracts, I could then begin to arrange broader discursive strategies that work to position homeopathic practice as a potentially contested and controversial form of practice (Potter and Hepburn 2005).

5.6 Approaching Data Analysis

In the following analytical chapters, 5–7, I apply Wetherell's (1998) proposed analytical framework by incorporating Edwards and Potter (1992) DAM as a method of analysis to three innovative data sets: namely, face-to-face semi-structured research interviews with (i) practitioners, (ii) their patients, (iii) and interactive question - answer sequences taken from the homeopathic consultation between both groups. Analysing talk and the subsequent discourses of homeopathy from these verbal contexts offers a flexibility to explore the participants' orientations and the situated activity sequences and constructions.

Chapter 6

Practitioners orient-to ‘alignment-with-medicine’ and ‘boosting-the-credibility-of-homeopathy’

Here, in the first of the analytical chapters, explicated is how ‘practitioners’ in the context of the research interview manage individual credibility through two broad strategies. In this context, the interviewees’ talk is viewed as co-constructed with the researcher, where the patterns of interaction exhibit the normativity of asking and answering of questions in the research interview setting. Accordingly, the findings show that managing individual credibility is accomplished only through specific ways of accounting that orient to sensitive practice.

First, I discuss the interactional elements of the research interview and show how they are compiled into particular activities, which, are constrained by specific norms and expectations. Second, in the alignment-with-medicine strategy, the findings show how practitioners account for their practices by aligning with notions of mainstream medicine and downgrade and criticise the alternative. Third, in the boosting-the-credibility-of-homeopathy strategy, homeopathy is presented as a practice that is potentially effective as a form of treatment when contrasted with mainstream medicine. However, the practitioners of homeopathy are responding with particular social actions in ways to counter the possibility of their being viewed as without credibility. Accounting in this way, the practitioners’ social actions work to enhance the credibility of their own practices. At the same time, they attend to and

manage issues in relation to their personal accountability and thus illustrate the controversial and contested nature of homeopathic practice.

What becomes relevant is that the discourse of the practitioners' is (re)produced in wider socio-political, cultural and historical contexts in a culture of scepticism that works to potentially and continually marginalise homeopathic practice from mainstream acceptance.

6.1 Interactional Elements of the Research Interview

The interactional elements of the research interview consist of the researcher's agenda and analytic ideas suggesting potential contaminated and biased trajectory. Therefore, the normative expectation which underpins interview data is the 'flood' of the researcher's categories and assumptions in this production of social interaction. This is demonstrated to be the case as the researchers' agenda is nonetheless what is generally talked about.

As a product of social interaction it will exhibit interactional design features showing the participants tacit understandings and expectations in the interview setting. Routinely, however, a researcher is likely to try and structure a interview in the normative order given (Lynch 2002). The data I had underpinned the structural framework available for interviews. However, I did not intend to represent and examine the routine norms and expectations relevant to interview data. For this present study I examined the broad discursive strategies relating to the non-sequentiality within the interview setting (see p 332 for a discussion on the merits of both the research interview and in naturally occurring data). Examples of my approach are explicated below.

6.2 The ‘alignment-with-medicine’ strategy

In the first discursive strategy talked-up in the context of the research interview, I identified how the interviewees account for and defend their everyday practices through the alignment-with-medicine strategy. The interviewees deploy the discursive resources made available to negotiate, defend, and sustain the credibility of their own practices as individual homeopaths. At the same time, interviewees attend to and manage issues in relation to personal accountability to counter any potential challenges to the credibility of their practices. They accomplish this by orienting to and aligning their practice with notions of mainstream medicine, while downgrading and criticising the ‘alternative’. In this case, the interviewees construct potentially factual representations of what is discursively available and where their place is within the proposed analytical scheme.

However, the outcome of the constructions of homeopathy in Extracts 5:1-5:5 is to present homeopathic practice as a downgraded alternative, in that medicine is invoked as the accepted yardstick for practice. By performing the social actions that they do, the wider effect of the interviewees’ strategy is to potentially and continually marginalise homeopathy from mainstream acceptance.

6.2.1 Practitioners Align with Medicine

This finding is observed and explained throughout the five extracts seen below:

Extract 6:1

1. CC: so what is a homeopath
2. D: what is a homeopath (.) well I'm not a homeopath
3. CC: = no
4. D: = I'm a homeopathic doctor
5. CC: yes (.) okay
6. D: = and a complementary medicine therapist practitioner (.) a
7. homeopath in the usual accepted eh (.) term is a layperson who's
8. using homeopathy not a medically qualified

The first analytical point I wish to make is that D's (the interviewee) strategy (with CC the researcher) in Extract 6:1 functions to enhance the credibility of D's practice. In so doing, D is observed to be attending to issues in relation to personal accountability. Through a defensive orientation of her practice, D constructs a distinction between a 'homeopath' (Lines 1, 2 and 7) and a 'homeopathic doctor' (Line 4). The talk is constituted to display the alternative practitioner in contrast to the 'homeopathic doctor' (Line 4), and at the same time to make relevant the specific features attributed to both the 'homeopath' and 'homeopathic doctor'. The features that D makes available are talked-up to be heard as an accurate portrayal of a 'homeopath' (Lines 2 and 7) as a 'layperson (Line 8) who's using homeopathy', in contrast to a medically qualified homeopathic doctor. This kind of formulation lends itself to manage rhetorically a sensitive issue by a critical inference that a 'homeopath' has potentially no formal medical training.

This is reinforced by the spontaneous invoking of the category of 'layperson' as a potentially problematic category. That is, the use of 'layperson' is constituted as a potentially negative attribute in relation to the 'homeopath'. By contrasting a 'homeopath' with a 'homeopathic doctor', D implicitly infers that the 'homeopath' is a downgraded alternative, positioned on the fringes, in contrast to the notion of mainstream medical practice, implying a potentially unequal status quo.

This is primarily characterised in relational terms by the way that D orients to and aligns favourably with the category of ‘homeopathic doctor’. This inference is reinforced by the spontaneous invoking of the notion of ‘layperson’ presented in relation to a ‘homeopath’.

In so doing, this brings into focus the notion of the ‘category entitlements’—that is, when people are structuring accounts, they will be justified by the entitlements of the category membership of the speaker. Therefore, people positioned in particular categories are assumed to have assured epistemological skills attributed to that category. Hence, category membership is discursively accomplished by the speaker to produce a particular effect. The precise meaning and subsequent action is seen as indexical, but the point of demonstrating category as a social construct produced in the ‘here and now’ as a contingently situated accomplishment is the interactive objective. D’s contingency in making relevant the contrast between the ‘homeopath’ and ‘homeopathic doctor’ is noticeably a descriptive social accomplishment and not to be interpreted as given, fixed social categories, and not ‘out there’ in the social world. Rather, this contrast is contingently revealed through an everyday social interaction (in the context of the research interview) with CC (Potter 1996a).

Therefore, negotiation and the opportunity to define the ‘homeopathic doctor’ and the ‘homeopath’ is a contingently formulated, continuous process that involves the co-constructed efforts of the individuals concerned, which are negotiated, resisted and produced within the discursive resources made available to each speaker (Edwards 1991). Furthermore, re-categorisation performs what Potter (1996) has referred to as the notion of ‘ontological gerrymandering’, a process whereby categories can be re-formulated so that one category is negotiated towards avoiding

other descriptions and versions, in order to draw attention to specific attributes that constitute a particular action, event, object, person or group.

Here, in Extract 6:1, in the research interview, what unfolds is an everyday negotiated sequence of events demonstrating the reflexive and indexical qualities of a discursively situated accomplishment of D defending, resisting, and ultimately aligning her everyday practice with notions of mainstream medicine. Edwards (1991), Edwards and Potter (1992), Potter (1996a), Potter and Wetherell (1987) and Widdicombe and Wooffitt (1995) observed that categories are the fundamental building blocks of the multiple versions and representations which are negotiated, produced, and sustained through social interaction. What becomes apparent on this occasion and in the examination of D's account is that the categories (building blocks) have been invoked, negotiated, and produced in and through interaction to serve specific actions. Consequently, as a discursive accomplishment, D is observed to be making relevant and aligning her practice with notions of mainstream medicine. This is achieved through the way that D orients to and aligns with the category of 'homeopathic doctor', which on this basis works to produce and constitute the category of 'homeopath' as an alternative. In doing so, homeopathic practice is talked-up in the research interview context both as a downgraded alternative to notions of mainstream medicine, which is the accepted yardstick for practice, and as a practice that is contentious and potentially controversial. I shall now discuss the discursive devices used to present her account as an authentic and factual reporting of events.

In a response to CC's request, 'so what is a homeopath' (Line 1), D offers a response by invoking 'what is a homeopath (.) well I'm not a homeopath' (Line 2), demonstrating how D rebuts CC's use of the category 'homeopath' in this way. D

follows this potentially critical stance and goes on to align her practice with notions of mainstream medicine, claiming ‘I’m a homeopathic doctor (Line 4) and a complementary medicine therapist practitioner’ (Line 6), in a forthright way. Significantly, ‘I’m a homeopathic doctor’ is designed to define D as a medically trained practitioner in contrast to the ‘homeopath’, and in D’s own terms—that is, by orienting to the specific category of ‘homeopathic doctor’ and at the same time displaying a misalignment with the ‘homeopath’. By adding doctor to the category of ‘homeopath-ic’, it takes on potentially different inferences that are imbued with a cultural significance, a particular professional knowledgebase, status, and credibility value. Therefore, the recognition as a ‘doctor’ (Line 4) is designed to promote the notion of the status and authoritative attributes of D in comparison to a ‘homeopath’. D’s ‘complementary medicine therapist practitioner’ (Line 6) offers possibilities to infer that she has developed further as a complementary medicine practitioner juxtaposed to being a doctor. The spontaneous invoking of the category ‘homeopathic doctor’ (Line 4), is contingently offered as a comparative frame to notions of the ‘homeopath’ (Lines 1, 2 and 7). This infers the taken-for-granted and commonsense notions and role of mainstream medicine and medical discourse as the yardstick for comparison.

D’s potential criticism, ‘a homeopath in the usual accepted ehh (.) term is a lay person who’s using homeopathy, not a medically qualified....’ (Lines 6-8), is designed to draw an explicit distinction between a ‘homeopath’ and ‘homeopathic doctor’. On this occasion, D can be heard to externalise the utterance by drawing on mundane talk, displaying her inferences as a commonsense notion, as a way of talking-up what any neutral competent witness would observe (Potter 1996a).

She achieves this by deploying the discursive device of consensus and corroboration through invoking ‘the usual accepted term...’ (Line 7). Implicit is the way this suggests that unspecific others would observe the ‘homeopath’ as having these features. In so doing, D constitutes the utterances to be heard as merely reporting a usual and accepted mutually intelligible commonsense notion. D constructs credibility, objectivity and factuality by adding ‘out-there-ness’ to the claims being made (Potter 1996a; Horton-Salway 2001; Wooffitt 1992). Here, the manner in which I identify ‘out-there-ness’ follows Potter’s (1996a) description, according to which one constructs an account as independent of the agent doing the production, which effectively is how discursive externalising devices are deployed. The effect is that the speaker portrays the normativity of an everyday event, emphasising their actions, whilst attending to the *prima facie* credibility of the subsequent account. D can thus be heard as a credible and reliable speaker concerning the claims being made.

A final element is that by invoking the category of ‘lay person’ (Line 7), through this specific strategy, D positions the homeopath and the ‘homeopathic doctor’ (Line 4) as dichotomised categories that can be seen as two contrasting formulations of the ‘homeopathic’ practitioner. D, in this instance, constructs and constitutes the ‘homeopath’ (Lines 1, 2 and 7) as a criticised downgraded alternative to medically oriented practices, which ultimately positions the ‘homeopath’ on the fringe of mainstream medicine and as an ‘alternative’. In the various social actions described above, D is observed to be building up her case to align her practice with medicine. D accomplishes this primarily through an individual defensive orientation of her practices.

Extract 6:2

1. CC: so (.) what qualities are needed to become a homeopath
2. HP: I would make a distinction between homeopathic doctor and a (.)
3. CC: okay
4. HP: homeopathic practitioner because anybody can study homeopathy
5. and prescribe it and therefore to be named a homeopath it's not a
6. restrictive
7. CC: = yes ehh (.) mhm
8. HP: label but if you mean ehh (.) mm the qualities to become a
9. good one then [((laugh))]
10. CC: [((laugh))]
11. HP: = ((laugh)) I think you require considerable professional knowledge of
12. medicine psychology psychiatry

In Extract 6:2, HP (the interviewee) negotiates and defends her individual practice in order to maximise and sustain her practice as credible. In a similar strategy to D's, here the explicit performatives in HP's account make available a distinction between a 'homeopathic doctor' (Line 2) and a 'homeopathic practitioner' (Line 4) as a way of attending to the credibility of her practices. This also provides HP with a way to align her practice with mainstream medicine. HP portrays the potential qualities of a 'good' practitioner in relation to adequate professional knowledge, consisting of notions in relation to medicine, psychology and psychiatry. This suggests that the contrast between 'homeopathic doctor' and 'homeopathic practitioner' is based on distinctive professional accomplishments—namely, in academic subjects, in comparison with the mere alternative of homeopathy, ('anybody can study...' Line 4). In defending her practice, HP constructs a case portraying the 'homeopath' (Line 5) as a potentially contested and controversial notion. Therefore, by contrasting a homeopathic doctor and homeopathic practitioner in a medical and non-medical evaluative frame, HP is establishing and legitimising the homeopathic doctor as the taken-for-granted yardstick by which to measure everyday practices (Wetherell 1998). In accomplishing this differentiation, in her talk HP is observed to

be aligning her everyday practice with notions of mainstream medicine and presenting the homeopath as an alternative on this basis. The downside of HP's producing her strategy in this way—the wider effect of the inferences made through discourse—is that it works to present homeopathic practice as a contentious knowledge claim in many ways.

Second, in direct response to CC's request, 'so (.) what qualities are needed to become a homeopath' (Line 1), HP makes the following relevant to the interaction: 'I would make a distinction between homeopathic doctor and a homeopathic practitioner' (Lines 2-4). The framing of 'what qualities...' (Line 1) by CC is not immediately referred to by HP. Here there is a shift in the focus as HP's response can be heard as a potential resistance to the use of CC's category of 'homeopath' on this occasion. This is achieved by the way that HP avoids responding to 'what qualities are needed...' (Line 1) in favour of negotiating a distinction between 'homeopathic doctor' and the 'homeopathic practitioner'. HP follows this with a potentially critical offer, claiming 'anybody can study homeopathy and prescribe it and therefore be named a homeopath it's not a restrictive label' (Lines 4-6).

One practice in legitimising claims involves the extreme-case formulation. In this instance 'anybody' (Line 4) can be heard as an extreme-case formulation designed to propose that the study of homeopathy is widely available—indeed, it formulates the prevalence of 'anybody' (Line 4) as the proportion of those who can become a 'homeopath' (Line 5). Therefore, 'anybody' (Line 4), is proposed as evidence emphasising the excessiveness of unspecified others who can study and prescribe homeopathy and thus be known as a 'homeopath'. HP follows this by qualifying her claim: 'it's not a restrictive label' (Lines 5-6). On this basis, 'anybody' (Line 4) is an extreme-case formulation. Pomerantz (1986) identified three uses of

extreme-case formulations in everyday talk: to defend against or counter challenges to the legitimacy of complaints, accusations, justifications, and defences; to propose that a phenomenon is ‘in the object’ or objective rather than a product of the interaction or of circumstances; to propose that some behaviour is not wrong or is right by virtue of its status as frequently occurring or commonly done. In talking-up her response like this, HP is implicit in the way that she justifies the claim that ‘anybody’ (Line 4) could not become a ‘homeopathic doctor’ (Line 2). CC’s minimal token of acknowledgement ‘= yes eh (.) mhm’ (Line 7), is offered to HP, making relevant an agreement to continue talking without interruption or that CC is attending to encouragement as a normative expectation and strategy in the research interview.

Next, HP makes relevant ‘but if you mean eh (.) mm the qualities to become a good one then ((laugh))’ (Lines 8-9), which can be heard as a disclaimer to counter her response to being heard as someone who is potentially biased or prejudiced towards homeopaths (Hewitt and Stokes 1975). However, this is offered immediately prior to ‘((CC: ((laugh)) HP: = ((laugh)) I think you require considerable professional knowledge of medicine psychology psychiatry’ (Lines 9-12). The laughter that both CC and HP display suggests that in some way the inferences produced are a joke, as ironic or problematic in some way.

More than this, the utterance implies that to become a ‘homeopathic doctor’ (Line 2), the criterion is based on the notion of merit and attributed to a wide knowledgebase in relation to notions of medicine, psychology and psychiatry. Therefore, by building up the contrast between practitioners, HP invokes precise attributes of the ‘qualities to be a good one’ (Lines 8-9) (a practitioner), which include academic knowledge attributed to notions of medicine, psychology and psychiatry. In so doing, HP adds factuality, objectivity and credibility to the claims being made and

at the same time builds up positive inferences and simultaneously attends to her personal accountability as a practitioner in relation to the 'homeopathic doctor'(Line 2) that HP is observed to be implicitly in alignment with.

When referring to the potentially good qualities of the practitioner, HP constructs 'I think you require considerable professional knowledge of medicine psychology psychiatry' (Lines 11-12), demonstrating what could be heard as alignment with the above professional topics. HP's 'I think' (Line 11) on this occasion is offered as a potential assessment with an orientation to a broad range of topics (Edwards and Potter 2005). Moreover, in informing CC with 'I think you require...' (Line 11), HP displays the contingency of the inferences made, and this is a further way of attending to the responsibility of accountability by making it difficult to counter HP's argument.

By invoking 'medicine psychology psychiatry' (Line 12), HP constructs her response in a three-part list discursive device that is packaged to emphasise the diversity of mundanely accepted professional knowledge considered representative of a 'homeopathic doctor' (Line 2). Previous writers argue that the three-part formulation is treated as a complete underlying principle when constituting list formations (Jefferson 1990; Wooffitt 1992). In general, specifically drawing upon three-partedness in a list construction is used as a discursive device to underpin factual impression, adding credibility to HP's description. It is suggested by Jefferson (1990) that three-partedness is a normative principle underlying people's actions and a normative organisational feature of everyday talk. Generally, lists have three parts and they are complete only at the provision of the third item. Often one can be found to add 'et cetera' or a suitable third element to complete a list (Jefferson 1990; Potter 1996). On this occasion, HP's three-part list adds rhetorical strength to her claims and

at the same time emphasises the diversity of the homeopathic doctor's knowledgebase, namely in 'medicine psychology psychiatry' (Line 12). The list does this whilst assisting HP in working up an explicit response to CC's request. This claim by HP is in contrast to the potential criticism of the 'homeopath' (Line 5), who apparently studies solely homeopathy—inferring that the 'homeopath' is possibly limited in a professional context.

By orienting to notions in relation to medicine, psychology and psychiatry, HP aligns her practice with mainstream medicine as discursive resources made available and relevant for consideration.

Extract 6:3

1. CC: so what qualifications do you think you need to practice homeopathy
2. U: I think it is important being a doctor actually (.)
3. CC: yeah
4. U: = yes (1) because ehh (.) we had students sitting in from ((name of
5. institution)) nursing students and maybe it's just the nature of our
6. clinic but we actually see a lot of chronic disease (.) and I feel that you
7. need a medical background to (.) to know what is going on because
8. sometimes we do pick up things that GPs haven't
9. CC: uh huh (.) mm
10. U: and ask the GP to look into it
11. CC: mm
12. U: and quite how lay homeopaths would get on in that situation I don't 13.
- know but then they don't have the advantage of using hospital notes
14. CC: yeah (.) mm
15. which we do

In Extract 6:3, U's (the interviewee) social actions can be observed to be explicit in the way that she works up through a defensive orientation to enhance the credibility of her practice—namely, by emphasising the importance of being viewed as a doctor knowledgeable to practice homeopathy. Subsequently, U talks up a credible and persuasive version of events to justify her claim. This is followed by U's suggestion that the nature of the clinic is primarily in the treatment of chronic disease,

which is used as a rationale and justification for the need for knowledge from a medical background. U's account is furnished further by invoking 'nursing students' (Line 5) and the 'lay homeopath' (Line 12), who are criticised and portrayed as possibly inadequate to deal with such a clinic. U justifies her claims by offering: 'we do pick up things that GPs haven't' (Line 8) 'and ask the GP to look into it' (Lines 10) and 'have the advantage of using hospital notes' (Line 13) as a way of constructing her own personal credibility.

Moreover, U works up these notions as positive attributes unique to her practice as a 'doctor' (Line 2). As a discursive accomplishment, U can be seen to align her practice with notions in relation to mainstream medicine as a way of talking up the credibility of her practice and to present a factual version of events. At the same time, U makes explicit circumstances where the 'nursing students' (Line 5) and 'lay homeopath' (Line 12) are, on this basis, apparently constrained and portrayed as alternative when contrasted with notions of medicine. The potential downside to constructing her discursive strategy in this way is to present homeopathy as situated in a culture of scepticism oriented to as an alternative troubled 'type' of practice.

U manages this as a discursive accomplishment by making relevant and spontaneous responses to what is heard as a request from CC. CC's question, 'so what qualifications do you think you need to practice homeopathy' (Line 1), is designed to elicit a response from U regarding an evaluation of the level to practice. U responds accordingly and explicitly with 'I think it's important being a doctor actually' (Line 2), implying that the practices of mainstream medicine are an appropriate gauge with which to evaluate and measure homeopathic practice. The use of 'I think it's important...', presented as a potential assessment on this occasion, is the way that U

attends to the issue of ratifying and warranting the inferences made (Edwards and Potter 2005).

U justifies her practice as a doctor further with an account in relation to ‘students’ (Line 4) and ‘nursing students’ (Line 5). She claims, ‘yes (.) because ehh (.) we had students sitting in from ((name of institution)) nursing students and maybe it’s just the nature of our clinic but we actually see a lot of chronic disease’ (Lines 4-6). This is qualified with ‘I feel you need a medical background’ (Lines 6-7), inferring that ‘nursing students’ do not have the appropriate knowledge for a chronic clinic but the upgraded medical background is presented as acceptable for practice. As a result, U is observed to be talking up a medical perspective to practice, which U orients to and makes relevant to the interaction further into the account.

Here, I shall introduce the notion of ‘footing’. Consider the utterances, ‘we had students’ (Line 4), ‘we actually see a lot of chronic diseases’ (Line 6), ‘we do pick up things GPs haven’t...’ (Line 8), and ‘...hospital notes which we do’ (Lines 11-12) (both of which are invoked further on in U’s account): these illustrate a shift of footing. The notion of footing was identified and developed by Goffman (1981), who highlighted the different participant roles that people/agents have in the way they attend to and manage the production or reception of an utterance. That is, in canonical talk the one who actively speaks is identified as the animator; the one who has selected the words in the segment of talk that they are meant to represent is identified as the author; and the principal is someone whose beliefs have been told (Goffman 1981). Over the course of naturally occurring talk a speaker will invariably and consistently change his/her footing. However, footing shifts tend to appear when more contentious factual claims are made, concerned with issues of neutrality and the responsibility to one’s personal accountability. Footing can also be understood as part

of a more general issue of alignment and how far speakers are presenting some factual account as their own or distancing themselves. In this instance, U is issuing a formulation of the standpoint of a collective group presumably in connection with the medical fraternity. The effect is to add credibility, objectivity and persuasive value to the argument being made, and at the same time does not offer to be making factual claims on her own behalf. The effect is to counter any potential challenges concerning the attributional issue of responsibility when managing her accountability in terms of what she has said.

U goes on to defend her practice with, 'it's just the nature of our clinic' (Lines 5-6). The invoking of 'just' (Line 5) signals the unremarkable nature of what is being reported, namely 'the nature of our clinic' (Lines 5-6)—inferring that the clinic has a specific function apparently tailored to someone with a medical background. It is a way in which U attends to the objectivity and externalising the responsibility of the claim: it is not what U thinks; rather it is the specific attributes and requirements of the clinic.

According to Lee (1987), 'just' has a range of four distinct interpretations in varying contexts, such as depreciatory, restrictive, specificatory and emphatic. U's deployment of 'just' (Line 5) on this occasion functions to identify the limitation of the clinic by incorporating the 'restrictive' meaning. To further build up objectivity and credible evidence to add persuasiveness to her account, U cites 'students sitting in from ((name)) nursing students' (Lines 4-5) as a way of drawing upon consensus and corroboration, particularly by claiming that students have experienced 'sitting in' (Line 4). This infers that on previous occasions both U and 'students' (Line 4) observed a similar experience. By invoking 'students' (Line 4) as the source of information in relation to witnessing an event, U works up greater factual significance

into the segment of talk by the corroborative evidence of the ‘other’. The consensus is displayed through the apparent way that both parties experienced the proposed event as something that happened. U’s reporting in this way further establishes the corroborative and persuasive aspects of the claims being made (Horton-Salway 2001; Wooffitt 1992).

U justifies her practice with ‘we actually see a lot of chronic disease’ (Line 6). This can be heard as a way of portraying everyday practice as somewhat specialised in relation to ‘chronic disease’ (Line 6), inferring that it is problematic for the ‘nursing student’ (Line 5) and subsequently the ‘lay homeopath’ (Line 10) to acquire knowledge of such a topic. In addition, the notion of ‘chronic disease’ (Line 6) suggests that U regularly accommodates clientele that fall into this potential category associated with the terminally sick. The deployment of ‘a lot’ (Line 6) on this occasion is designed to make U’s description more effective by focusing on the extreme elements of judgement, inferring that ‘chronic disease’ (Line 6) is a frequent feature of the clinic. Furthermore, U’s use of ‘a lot’ at this point in the account is a description of the prevalence of the practice that proposes it is normal and acceptable, and that, by virtue of this, the subsequent behaviour is commonly observed. U is using the prevalence to speak for the rightness of the practice, which constitutes reliable and factual evidence justifying why a ‘medical background’ (Line 7) is imperative. This can be observed as an extreme-case formulation (Pomerantz 1986). This claim is in alignment with the claim above—it’s ‘just the nature of our clinic’ (Lines 5-6).

This is followed by an explicit construction from U to promote her practice, claiming, ‘I feel that you need a medical background to (.) to know what is going on because sometimes we do pick up things that GPs haven’t’, ‘and ask the GP to look into it’ (Lines 6-8 and 10), inferring that with a ‘medical background’ (Line 6) one is

in a unique situation to treat effectively and portray certain epistemological skills. In addition, 'a medical background' (Line 6) is also used and attributed as a resource to substantiate the claims being made by talking up the knowledgebase as objective.

U follows this with 'quite how lay homeopaths would get on in that situation I don't know but then they don't have the advantage of using hospital notes', 'which we do' (Lines 13 and 15). By invoking this, U is presenting a potential criticism of 'lay homeopaths' (Line 12). However, U manages the potential difficulties of this inference by attributing the notion of the lack of 'hospital notes' (Line 13) as the source of disadvantage to the 'lay homeopath' (Line 12), which adds objectivity to her claim. In this way U further manages and attends to the personal accountability of the claims she makes.

Furthermore, as part of stake inoculation, U cites 'I don't know' (Lines 12-13) to offset any potential challenge that she is in some way prejudiced or biased towards 'lay homeopaths' (Line 12). Considering this stance, Potter (1996) suggests that the question of stake is a key area of focus during every interaction; people treat each other as having vested interests, desires, motivations, and allegiances, that is, as having a stake in some position or other. If the speaker wants his/her version of events to be heard as the plain truth, then this has the potential to become problematic. People have different ways of managing stake, i.e. managing against inoculation. If one works up a description from an event in the past or from an accusation that insinuates blame on a particular person or a group, then one faces the possibility of having one's statement discounted on the grounds of 'stake and interest'. One may voice that one was originally sceptical of a chosen topic and later in the account claim to have been converted because of credible evidence. Therefore, interests and accountability are central to participants' productions of factual discourse, and thus, if

descriptions show these notions, it is considered that participants are exhibiting a dilemma over 'stake and interest'. Consequently, accounts can be produced that have interest, but are not undermined as interest. However, throughout accounts self-interest could be seen as a motivating factor and is so treated by the listener. In all interaction, the speaker will find ways to manage 'stake and interest'. On this occasion, U's 'I don't know' (Lines 12-13) is the discursive device that is deployed to manage the risk of the possibility that a description is a product to promote their version in a certain way. That is, 'I don't know' (Lines 12-13) is part of 'stake inoculation' to offset any potential challenge to her accountability and at the same time to provide the warrant for U to be observed as describing what any neutral, competent person would have witnessed, with the effect of externalising the event as objective (Potter 1996; Wooffitt 1992). Moreover, U's 'I don't know but...' (Lines 12-13) can be observed as a disclaimer (Hewitt and Stokes 1975). U's talk is designed to offset any possible challenge that she is prejudiced towards the 'lay homeopath' (Line 12). However, U follows this immediately with a potential criticism in relation to the homeopath, and boosts her own credibility by claiming 'then they don't have the advantage of using hospital notes' (Line 13) and 'which we do' (Line 15).

Finally, in constructing and constituting her factual defence of her practice with the resources and discursive devices made available, U aligns it with notions of mainstream medicine as a way of enhancing her practice as credible and attending to and managing the sensitive issues in relation to personal accountability for the claims and inferences she makes. In a similar response to the interviewees in Extracts 5:1 and 5:2, U works up homeopathic practice in her treatment of the potentially less favourable category of the criticised 'lay homeopaths' (Line 12) as downgraded alternatives.

Extract 6:4

1. CC: is there anything you'd like to add about homeopathy that we
2. haven't talked about or covered
3. CD: as a homeopathic doctor (.) I'd like to see lay practitioners coming
4. into one regulatory system (.) and more communication between
5. medical homeopaths and lay practitioners ehh (.) because I think (.)
6. there are some who probably tend to give the whole thing a bit of a bad
7. name and there's the ones that happen to be on the fringe that aren't
8. y'know properly regulated
9. CC: mhm mm
10. CD: there needs to be progress in medical homeopathy not only for me (.)
11. all lay practitioners ehh (.) because I have a burning desire to see
12. homeopaths become more accepted mainstream

In CD's (the interviewee) orientation to the alignment-with-medicine strategy, she talks up to advocate 'one regulatory system' (Line 4) and 'more communication' (Line 4) as possible topics of contention when discussing the contrasts between the categories of 'lay practitioners' (Lines 3 and 5) and 'medical homeopaths' (Line 5). Presented in a defensive orientation of her practices, CD spontaneously makes relevant potential criticisms in relation to 'lay practitioners' (Lines 3 and 5) who apparently 'give the whole thing a bit of a bad name' (Lines 6-7). Further, in CD's construction she makes relevant 'the ones (lay practitioners) who are on the fringe (of medicine) that aren't y'know properly regulated' (Lines 7-8) as a contentious and controversial issue. The interactional business being accomplished is that CD can be observed to be explicitly aligning her practice with notions of mainstream medicine in contrast to the alternative 'lay practitioner' (Lines 3 and 5). At the same time, CD is potentially critical of the 'lay practitioner' (Lines 3 and 5), who is portrayed as on the fringe of mainstream medical practices. CD presents the notion of progress in 'medical homeopathy' (Line 10) as the way to gain mainstream acceptance. However, the function of the strategy is to enhance the credibility of her practice. At the same time CD attends to issues of personal accountability in the way that she presents her

account as accurate and factual and by talking from the stand point of a 'homeopathic doctor' (Line 3).

CC's request in the context of the research interview, 'is there anything you'd like to add about homeopathy that we haven't talked about or covered' (Lines 1-2), is framed in such a way as to invite a general response from CD regarding the topic of homeopathy. CD responds immediately with 'as a homeopathic doctor...' (Line 3), which displays to CC that CD is talking from the standpoint of a medical practitioner. In doing so, CD, without prompting or coercion, aligns her practice with notions of mainstream medicine. CD follows this with 'I'd like to see lay practitioners coming into one regulatory system (.) and more communication between medical homeopaths and lay practitioners' (Lines 3-5) as a way of attending to a possible area of contention between practitioners. By invoking the category of 'lay practitioners' (Line 3), CD makes the 'lay practitioner' (Line 3) relevant to the interaction and to the account required.

CD deals with the 'lay practitioner' again in Line 5, by highlighting a contrast between 'medical homeopaths' (Line 5) and 'lay practitioners' (Line 5), which is attributed to notions of regulation and potentially unsatisfactory communication strategies. A further analytical point regarding the utterance 'I'd like to see lay practitioners coming into one regulatory system and more communication between medical homeopaths and lay practitioners' (Lines 3-5) is that it can be heard as being offered as a solution to the segment of talk that directly follows. More than this, CD can be observed to produce a potential criticism in relation to the 'lay practitioner' (Line 5). The design of the talk is such that CD is portrayed as merely reporting an event external to her individual human agency. In so doing, CD portrays it as talk that is representative of actual factual events relating to regulation and the dynamics

involved in the relationship between the ‘medical homeopaths’ (Line 5), and ‘lay homeopath’ (Line 5), and not the product of a critical sequence or with an axe-to-grind in terms of ‘lay homeopaths’ (Line 5).

The account develops, with CD making a potential criticism in relation to the reputation of lay practitioners. CD makes relevant; ‘because I think there are some who probably tend to give the whole thing a bit of a bad name’ (Lines 5-7). By making a potential assessment and framing it as a criticism and describing the action ‘there are some’ (Line 6) as giving ‘the thing a bit of a bad name’ (Lines 6-7), CD makes sense of the apparent contrast between ‘medical homeopaths’ (Line 5) and ‘lay practitioners’ (Line 5) through distinguishing potentially negative attributions in relation to the latter. In doing so, CD attends to a potential criticism of the ‘lay practitioner’ and their conduct (Line 5).

Moreover, by making relevant and offering ‘I think there are some who probably tend...’ (Lines 5-6), CD works up the inferences to be attributed to external factors and thus presents her criticisms in relation to prior events, thereby emphasising the objectivity of the claims. The use of passive forms also works to diminish the notion that the criticism being made is motivated by self-interest. Rather, making relevant ‘there are some’ (Line 6) is a way in which CD manages an issue with her own personal accountability by reporting in a non-personalised way. In so doing, CD is heard to be potentially critical, which is attributed to ‘some’ (Line 6), ‘lay practitioners’ (Line 5). More than this, CD presents her accusation to be heard as reporting what any neutral, competent observer would report in a similar situation (Potter 1996). CD furnishes her account further with ‘and there’s the ones that happen to be on the fringe that aren’t y’know properly regulated’ (Lines 7-8), to add a further criticism regarding their practice. Furthermore, this potentially controversial

accusation suggests that the ‘lay practitioner’ (Line 5) is on the periphery and presented as in some way accountable for their practice. The effect is to work up the ‘lay practitioner’ (Line 5) as potentially unprofessional and as a downgraded alternative when contrasted with the ‘homeopathic doctor’ (Line 3).

CD constructs an explicit claim in relation to ‘medical homeopathy’ (Line 9), by making relevant, ‘there needs to be progress in medical homeopathy not only for me (.) all lay practitioners’ (Lines 10-11). This works as a way to explicitly align her practice to notions of medicine and as a way to apparent progress. This is followed immediately with CD observed to be talking up her own individual agenda in the promotion of homeopathy. CD states, ‘because I have a burning desire to see homeopathy become more accepted mainstream’ (Lines 11-12), suggesting that this view is to counter the taken-for-granted and generally knowable notion that homeopathy is in some way problematic, contested and controversial, and apparently not readily credited in general. In doing so, CD introduces a set of inferences to furnish that she is sharing cognitive knowledge presented as an inner aspiration—‘I have a burning desire...’ (Line 11). More than this, CD offers an appraisal that works to bolster the credibility of her practice in contrast to the critical inferences made in relation to the ‘lay practitioners’ (Lines 3, 5 and 11). In making these resources available here, CD portrays the event as any neutral competent observer would experience it in a similar situation, which is a way of attending to issues of personal accountability for the claims she makes (Garfinkel 1967; Wooffitt 1992).

Finally, the interactional business serves CD as a way to defend and align her practice to notions of mainstream medicine—the ‘homeopathic doctor’ (Line 3) and ‘medical homeopaths’ (Line 5)—in an evaluative and possibly critical frame, with ‘lay practitioners’ (Lines 3, 5 and 11) positioned an alternative on this basis. This is

produced as a way of enhancing the credibility of her practice and at the same time of building up the facticity, accuracy and truth aspects of her claims, and making it difficult to challenge her accountability of the claims being made.

Extract 6:5

1. CC: what do you see as the differences between a homeopath and a
2. healthcare practitioner
3. WS well I'm an orthodox GP (.) so (.) there's no reason why lay
4. homeopaths shouldn't be involved in the system(.) I as long as it's
5. alongside orthodox doctors doing the diagnosing (.) and that was one of
6. the good things about the 1990 (.)GP contract (.) was that was the first
7. time it was not uncommon for (.) ehh (.) orthodox GPs (.) I would
8. work alongside lay homeopaths to provide a clinic in a medical centre
9. (.) so there are ways forward but again it comes back to everybody
10. getting used to each other and comfortable with each other (.) training
11. together and them getting away from these extreme viewpoints (.) it (.)
12. needs to be with orthodox GPs

The first analytical point to note is that WS's (the interviewee) construction is situated in a defensive orientation of his practice, which functions as a discursive strategy to enhance its credibility. WS constructs what can be heard as a credible, factual and persuasive argument to justify the involvement of 'lay homeopaths' (Lines 3-4 and 8) working in juxtaposition with orthodox GPs. In many ways, it can be heard as if he is promoting orthodox GPs' and his own practices. However, the potential conditions he is promoting are presented in a somewhat contradictory frame as WS makes available that the criteria required would involve 'orthodox doctors doing the diagnosing', suggesting that this depends on specific conditions in relation to the '1990 GP contract'. By discussing the details of the '1990 GP contract' (Line 6) as essential in allowing 'orthodox GPs' (Lines 7 and 12) and 'lay homeopaths' (Lines 3 and 8) to have a medical clinic together, WS aligns his practice with notions of mainstream medicine. In doing so, WS works to bolster his individual credibility. WS presents the 'lay homeopaths' (Lines 3-4 and 8) in a implicitly contentious critical

frame and as a downgraded alternative when evaluated in the broader social context, with the taken-for-granted framework of mainstream medicine as a contrast. WS's account is furnished further as he provides information on ways forward, suggesting that 'everybody' (Line 9) could engage collectively and with similar goals as a possible solution to working together. By constructing his account and referring to topics in this way, WS identifies that there is a division and potential problematic gap between 'lay homeopaths' (Lines 3-4 and 8) and 'orthodox GPs' (Lines 7 and 12). At the same time, WS works to manage his accountability by attending to the potential bias that he might be accused of in the event of a counter-challenge in relation to the amalgamation between practitioners.

However, in doing so, WS talks up such an amalgamation of practitioners' conditions by referring to 'extreme viewpoints' (Line 11) rather than to his own individual view. Significantly, WS defends his own practice and aligns it with that of the 'orthodox GP', whilst making the category 'lay homeopath' relevant as something alternative and positioned in a culture of scepticism, but apparently manageable if particular and specific conditions are met. Consequently, WS is heard attending to issues of status, credibility, and managing the responsibility for his personal accountability in relation to his everyday practices.

In CC's formulation 'what do you see as the differences between a homeopath and a healthcare practitioner' (Lines 1-2), no mention of a 'lay homeopath' or reference to 'orthodox doctors' is made in the framing of the potential question. In CC's formulation, he is explicitly fishing for a response that may elicit talking about contrasting practitioners. Accordingly, this utterance is heard as a request by WS, who responds with 'well I'm an orthodox GP (.) so there's no reason why lay homeopaths shouldn't be involved in the system as long as it's alongside orthodox doctors doing

the diagnosing' (Lines 3-5). WS makes relevant the category of 'orthodox GP' (Line 3), 'orthodox doctors' (Line 5) and 'lay homeopaths' (Lines 3-4) in a contrasting defensive orientation as a way of justifying the diverse and contentious roles of both the 'orthodox GP' (Line 3) and the 'lay homeopaths' (Lines 3-4). In so doing, WS immediately and spontaneously invokes and attributes possible conditions for working together—namely, that of diagnosing and having 'orthodox GPs' as the main decision makers. Further, this suggests that such a reference can usefully be regarded as reflecting the prevailing construction of the 'lay homeopaths' (Lines 3-4) as an alternative, in contrast to 'orthodox doctors' (Line 5). By making 'orthodox doctors' relevant in this context, WS formulates potential attributes to offer a possible explanation to display why 'lay homeopaths' (Lines 3-4) are on the fringe in relation to 'orthodox doctors'/GPs and their practice of 'the diagnosing' (Line 5). In so doing, WS invites 'lay homeopaths' (Lines 3-4) to be part of the 'medical' system.

This is followed immediately by a potentially positive attribute in relation to the 1990 GP contract. WS's claims—'that was one of the good things about the 1990 (.) GP contract (.) it was that was the first time it was not uncommon for (.) ehh (.) orthodox GPs (.) I would work alongside lay homeopaths to provide a clinic in a medical centre' (Lines 5-8)—are designed to manage two types of issue: to promote and illustrate precisely a specific time, '1990' (Line 6); presenting a document referred to as a 'GP contract' (Line 6) as evidence of 'orthodox GPs' (Line 7) and 'lay homeopaths' (Lines 3-4 and 8) working together in a medical clinic. At the same time, this description mitigates the possibility of WS being seen as in some way biased towards the 'lay homeopaths' (Lines 3-4 and 8) and promotes a collegial approach. More than this, it positions the 'orthodox GP' (Line 7) as potentially progressive in their approach to the homeopath. In addition, these references to the '1990 GP

contract' (Line 6), 'orthodox GPs' (Line 7) and 'lay homeopaths' (Lines 3-4 and 8) can be heard to deploy consensus and corroboration as a device designed to build up factuality and credibility, and to add objectivity and persuasiveness to the claims being made (Horton-Salway 2001). Therefore, working up and attributing the '1990 GP contract' (Line 6) as an organisational framework between 'orthodox GPs' (Line 7) and 'lay homeopaths' (Lines 3-4 and 8) can be observed as portraying corroborative evidence for the claims being made. The design and use of the '1990 GP contract' (Line 6), 'orthodox GPs' (Line 7) and 'lay homeopaths' (Lines 3-4 and 8) is the way that WS externalises and accounts for consensus with regards to his claim to be heard as a reliable source, and suggests mutual consent as part of fact construction and as a way of attending to and managing issues of personal accountability by countering any potential challenges to the claims being made (Edwards and Potter 1992).

To further bolster facticity and the external aspects of his account, WS provides the construction 'there are ways forward but...' (Line 9), which is a discursive device to head off or disclaim the possible implication that he is observed as implying any potentially obnoxious attributions (Hewitt and Stokes 1975). Here, WS counters the assumption that he is one of those people who is in opposition to progress. This is followed by WS constructing a counter-claim in a list-format - 'it comes back to everybody getting used to each other and comfortable with each other (.) training together and them getting away from these extreme viewpoints' (Lines 9-11). Here, WS's list portrays a tacit suggestion that the items made relevant on the list are attributes relevant to both the 'orthodox doctor' (Line 5) and the 'lay homeopath' (Lines 3-4 and 8). The inferences in the list-format emphasise the contrast between an apparent precognitive knowledge and the various dimensions in relation to areas of

divergence that are constructed and presented as commonsense knowledge. Constructing a list formulation with the components ‘getting used to each other’ (Line 10), ‘comfortable with each other’ (Line 10) and ‘training together’ (Lines 10-11) infers that in some way there are areas of contention, while ‘them getting away from these extreme view points’ (Line 11) is potentially critical in relation to the views of the ‘lay homeopaths’ (Lines 3-4 and 8).

WS thus displays a broad range of contested, controversial issues between practitioners. The wider implication of WS’s list construction is to work up the objectivity of the attributes made relevant, and at the same time to diminish his own human agency and the possibility of being heard as prejudiced or biased. This is followed by WS’s potential bolstering of his own practice. He claims, ‘it (.) needs to be with orthodox GPs’ (Lines 11-12), which works to position the ‘orthodox GP’ in the role of an evaluative authority.

A further analytical point regarding this inference is that WS’s reporting of the prevalence of the practice (in claiming ‘it comes back to everybody getting used to each other and comfortable with each other...’ (Lines 9-10)) can be heard as an extreme-case formulation: to propose that to achieve ‘ways forward’ (Line 9) there has to be an exceptionally high ratio of non-specific people carrying out the apparently unified approach, such as everybody/does/thinks/knows X. In this instance, ‘everybody’ (Line 9) is a discursive device for attributing that a large number of people carrying out similar activities can achieve ‘ways forward’ (Line 9), and is used as a persuasive function to justify the claim being made. On this occasion, the emphasis on ‘everybody’ (Line 9) proposes that the proportion is whole and complete and is offered as a solution. It is heard as an extreme-case formulation to bolster WS’s inferences and thus maintains the attributes relevant for such a function (Pomerantz

1986). The device is invoked to bolster the factuality and authenticity of the claim by emphasising frequency as significant.

A final analytical point in terms of WS's account is the way that throughout he is observed to mundanely accept the 'lay homeopaths' with 'orthodox doctors and orthodox GPs' (Lines 3-4 and 8) as in an evaluative two-class set. By aligning his practice with notions of mainstream medical practices, WS is critical of the 'lay homeopaths' 'extreme viewpoints' (Line 11), presenting them as a contentious controversial downgraded alternative located in a culture of scepticism when contrasted and evaluated in this discursive contrasted framework.

6.2.2 Summary of the Analysis in Extracts 6.1-6.5

At one level, in the above Extracts (6:1-6:5) concerning the alignment-with-medicine strategy, homeopathic practice is negotiated, produced and sustained in the research interview context in alignment with notions of mainstream medicine and criticises the alternative 'lay practitioner'. Therefore, the function of the strategy is to enhance the credibility of their practices and to counter any potential challenges and thus making personal accountability a relevant interpersonal issue.

However, just as significant, by way of a final analytical point, from a 'top down' perspective this strategy then has wider implications for the understanding of contested and controversial homeopathic practices in the ways that conventional medicine is the taken-for-granted accepted yardstick for practice. In making this distinction, the boundaries of what is and what is not acceptable are judged on conventional medical territory. In doing so, the wider effect is to present homeopathy

as situated in a culture of scepticism oriented to as an alternative troubled ‘type’ of practice positioned on the fringe of the modern medical market.

Therefore, the findings illustrate how potentially disempowering ways of talking rest upon and are informed by alternative or opposing ideas, and the broader discourse shows how forms of social organisation perpetuate potential inequalities and maintain and sustain the power and influence of the dominant mainstream medicine that is carried out in everyday medical encounters. The wider effect has the potential to continually marginalise homeopathy from mainstream acceptance if linked to the broader socio-political, historical and cultural contexts (Wetherell 1998).

However, other interviewees do not seek to defend their practices solely by reference to alignment with mainstream medical practices but by bolstering the credibility of homeopathy.

Therefore, in contrast I now introduce a series of Extracts, 6:6-6:12, where the emphasis is still on enhancing the credibility of their own individual practices—but on these occasions by boosting-the-credibility-of-homeopathy through various social actions.

6.3. Boosting-the-credibility-of-homeopathy strategy

As highlighted, other interviewees do not seek to defend their practice solely with the alignment and reference to mainstream medicine. Rather, the emphasis is on talking up and boosting the credibility of homeopathy. In the boosting-the-credibility-of-homeopathy strategy, the function is to enhance the credibility of the interviewees’ practices and in so doing attend to and manage issues of personal accountability. I demonstrate through Extracts 6:6-6:12 the ways in which the interviewees deploy the

discursive resources made available to emphasise the potential benefits of homeopathy and work up the credibility of their practices.

This is achieved over a range of ways—namely, by deploying the (mundane) ‘X’ then (extraordinary) ‘Y’ device (Jefferson 1984a; Wooffitt 1992), (Extracts 6:6, 6:7 and 6:8) or through ‘troubles telling’ talk (Jefferson 1984a; Jefferson and Lee 1981), or/and by undermining potential criticisms, and combined with various discursive devices deployed to maximise the persuasive power of the inferences and social actions being performed (Edwards and Potter 1992). For the interviewees, individual credibility is accomplished through specific constructions of homeopathy. More than this if the talk-about-homeopathy is considered from a ‘top-down’ perspective, the wider effect is illustrated to potentially and continually marginalise it from mainstream acceptance. These ways of accounting are observed and broader effects are explicated throughout the subsequent extracts.

6.3.1 Applying the (Mundane) ‘X’ then (Extraordinary) ‘Y’ Device

In Extracts 6:6, 6:7 and 6:8, all the speakers adopt specific ways of accounting that are intended to work up the ordinariness of the events. This, as an activity accomplishment, is achieved by depicting homeopathic practice within an everyday setting as resulting in a potentially exceptional outcome by deploying the (mundane) ‘X’ then (extraordinary) ‘Y’ discursive device (Jefferson 1984; Wooffitt 1992). That is not to say that the speakers are unexceptional people; rather, the interactional business functions to build up the credibility of their homeopathic practices in this way. Furthermore, there is the way that the speakers handle contentious and potentially controversial topics in relation to their homeopathic practices. This is

achieved by deflecting attributional inferences about their own potentially biased descriptions as a way to promote the externality of the event. In accounting in this way, the speakers work to implicate the contingency of the event upon another. Therefore, the circumstances and events are constructed as objective—‘out-there’ (Edwards and Potter 1992)—and as something to be discovered rather than as a discursive product of their own self-interest presented and constituted in research interview talk about homeopathic practice (Potter 1996; Wooffitt 1992).

Extract 6:6

1. CC: could you tell me some thing about yourself
2. NS: ...ehh (.) I'll tell you how I came to homeopathy (.) I've always been
3. interested in alternative things ways of living (.) eh um but not really
4. looked into (.) alternative medicine very much but when my son was
5. ehk um (.) one year old which is twenty years ago now ehk um (.) he
6. had constant ear infections one winter and ehk after getting normal
7. treatment antibiotics about three (.) ehk um (.) we just thought it's not
8. good enough I went to some classes in homeopathy found (.) ehk (.)
9. with some help from the person who was giving the classes (.) the
10. homeopath I found a remedy that would stop ear infections instantly

Extract 6:6, was taken at the very beginning of the research interview with NS (the interviewee). By immediately talking about homeopathy, NS makes relevant that the interaction is pertinent to the research interview. It seems that there is an enormous amount of social action made available for analysis. Here, however, I shall focus on NS's detailed narrative construction and the implications for the attribution of cause, which is identified by discussing both the referential and evaluative functions. Rather than interpreting such a sequence as merely the passing on of neutral, accurate information, NS's apparently biographical account sets parameters for what is to be made discursively relevant. What is revealed is the way in which NS orients towards boosting-the-credibility-of-homeopathy strategy as a way of building

up and enhancing his own individual practice as credible. Essentially, homeopathy is constituted in the contingently formulated context as something that is oriented towards after the apparent limitations and failure of medicine, with potentially exceptional results. NS works up and attributes positive characteristics in relation to 'homeopathy' (Line 2) as a solution to his son's 'constant ear infections' (Line 6), claiming 'I found a remedy that would stop ear infections instantly' (Line 10). This can be heard as homeopathy having apparent, intrinsic therapeutic benefits. Significantly, the wider effects are that 'homeopathy' as a form of treatment is worked up as an alternative treatment option to 'normal treatment antibiotics' (Lines 6-7), and thus on this basis homeopathic practice is negotiated, produced and presented as a treatment with potential benefits. In so doing, NS is observed to be boosting the credibility of homeopathy. At the same time, the inferences work to position homeopathic practice as an alternative potentially on the margins of mainstream medical practices, oriented to and thus presented as a 'last-resort-form' and 'type' of practice.

As a way of accomplishing this, NS draws upon the device 'At first I thought... (mundane X), but then I realised...' (extraordinary Y) (Jefferson 1984; Wooffitt 1992) to promote the externality and subsequent facticity of the event. By using this type of construction, NS attends to the passing on of potentially contentious information while managing issues in relation to attending to his own personal accountability and countering any potential challenges to his practice. Therefore, NS presents his broad strategy in such a way that any 'ordinary' neutral, competent observer would observe the events in that situation. This is one way in which NS works up credibility and persuasiveness in presenting his argument. Significantly, there are parallels with this kind of format that were identified by Wooffitt (1992)

during a study of accounts by people who claimed to have had supernatural or paranormal experiences. However, by drawing upon this device it indicates to the listener that the phenomenon is possibly highly contentious, controversial and contestable, suggesting that the speaker has potential difficulties in making his talk, account and social practices credible.

In a response to CC's utterance, 'could you tell me something about yourself' (Line 1), NS immediately and spontaneously invokes 'I'll tell you how I came into homeopathy' (Line 2) as relevant to the interaction, which infers that NS heard CC's utterance as a request. However, the response from NS is to shift the focus away from CC's frame of 'something about yourself' (Line 1) to an appreciation of homeopathy. This shift has parallels with what Jefferson (1984) referred to as 'the stepwise transition'. This is a device whereby the speaker, when 'troubles telling', attempts to move from one uncomfortable or contentious topic to another without explicitly ending one topic and introducing the new one. Here there is a shift from NS not so much in the topic but in the frame or focus in which the question was set. Further, NS's narrative orientation is scene-setting for what will follow. He invokes, 'I'll tell you how I came to homeopathy' (Line 2) as a potential attribution story concerned with bolstering homeopathic practice in combination with an immediate and intimate personal experience. In doing so, NS invokes the (mundane) 'X' properties from line 2-10 in the way he talks up the ordinariness of the event of discovering homeopathy.

This is followed persuasively with 'I've always been interested in alternative things ways of living (.) eh um but not really looked into alternative medicine very much' (Lines 2-4) as a potential denial of having any prior interest in 'alternative medicine'. By making the categories of homeopathy (observed in line 2), 'alternative things' (Line 3) and 'alternative medicine' (Line 4) relevant for consideration, NS

explicitly formulates these categories in alignment. This infers that they have inherent characteristics as part of a homogenous group and that homeopathy is in some way synonymous with ‘alternative medicine’ (Line 4).

Moreover, NS’s claim, ‘but not really looked into alternative medicine very much’ (Lines 3-4) can be heard as a way of inoculating against a possible counter-challenge on the grounds of self-interest, which is a way of managing a potential issue in relation to the responsibility for his personal accountability. On this occasion, the stake inoculation of ‘but not really looked into alternative medicine very much...’ (Lines 3-4) works to counter the possible suggestion that NS had displayed a prior vested interest in promoting homeopathy as an alternative medicine, and at the same time counters any potential challenges, which is one way of attending to his personal accountability (Potter 1996). Moreover, denying looking into alternative medicine—presented in the design of a disclaimer—further works to emphasise NS’s complex use of rhetoric to downplay his self-interest (Hewitt and Stokes 1975).

To further build up objectivity and facticity, NS’s construction is dated to a specific point in time, ‘when my son was ehum (.) one year old which is twenty years ago now’ (Lines 4-5), adding precise detail to the event. This inference is grounded in the following sequence of events and is scripted and attributed as any mundane accurate life event—which is a good example of the mundane ‘X’: ‘he had constant ear infections one winter’ (Line 6). Moreover, this claim can be heard as an extreme-case formulation to strengthen NS’s rhetorical argument (Pomerantz 1986).

Here the rhetorical work of the extreme case is used to maximise the persuasive value by emphasising the potential negative attributes in relation to the ‘ear infections’ (Line 6). The invoking of ‘constant’ indicates the amount of time spent with the ‘ear infection’ as a large proportion of ‘one winter’ (Line 6). On this

occasion, NS's 'constant' proposes that the amount of time was unreasonably long. Hence, 'constant' is used to make the version more effective by focusing on the extreme elements of judgement (Pomerantz 1984). This extreme-case formulation can be heard as attributed to notions of mainstream medicine: 'and ehh after getting normal treatment antibiotics about three' (Lines 6-7). The account is contrasted, i.e. by drawing upon 'normal treatment antibiotics about three' (Line 7) (notion of mainstream medicine) as the attributional cause for looking to homeopathy. By claiming 'normal' (Line 6) and attributing it to 'treatment antibiotics' (Line 7), NS infers that possibly 'homeopathy' is treated as abnormal, suggesting that homeopathic practice is in some way contested, problematic and potentially controversial.

Significantly, NS orients vis-à-vis a comparative framework between alternative medicine/homeopathy and mainstream medicine as a way to evaluate and contrast aspects of homeopathy. In so doing, this can be seen to contribute to the taken-for-granted authority of medical discourse as the yardstick by which to measure, judge and evaluate treatment and everyday homeopathic practice. By emphasising the amount of times, 'three' (Line 7), in relation to the failed antibiotic treatment, NS is making specific the sustained effort of using antibiotics and is defending a potential counter-challenge to his own responsibility—to his personal accountability that he looked to homeopathic treatment on a whim.

A further point is the discursive device of consensus and corroborative evidence. NS emphasises a possible criticism: 'we just thought it's not good enough' (Lines 7-8). This is deployed to produce consensus and corroboration; to transform a description of events into a more solid, factual and credible account through citing the evidence of the non-specific other—'we' (Line 7) (Wooffitt 1992; Horton-Salway 2001). The use of the restrictive particle 'just' (Line 7), on this occasion, is in the

‘depreciatory’ context to minimise the significant and to downplay the comparison with ‘antibiotics’ (Line 7) by claiming ‘it’s not good enough’ (Lines 7-8) (Lee 1987). The consensus displayed in the factual claim involving both NS and the ‘other’— i.e., through the deployment of ‘we just thought’ (Line 7)—infers that they observed the event in the same way and thus makes it heard as objective. Further, the speaker will often construct an account by adopting the device of speaking on behalf of a group or society, thus glossing over his/her individual self-interest. Here NS’s ‘we’ (Line 7) provides the inference of talking on behalf of himself and the ‘other’. In this instance, NS draws upon the role of animator and principal in the absence of the author. Hence, the notion of footing is utilised to build up the authenticity of the claims and adds to the neutrality of the description (Goffman 1981).

NS describes a further sequence of events, claiming ‘I went to some classes in homeopathy’ (Line 8), to provide information that he received homeopathic knowledge by making an apparent action. Subsequently, the sequence unfolds with NS’s personal testimony and a claim about the efficacy of homeopathy: ‘with some help from the person who was giving the classes (.) the homeopath’ (Lines 9-10) and ‘I found a remedy that would stop ear infections instantly’ (Line 10). Here, by making relevant the ‘homeopath’ (Line 10), NS can be heard to add corroborative evidence for finding the remedy and at the same time bolsters potentially positive characteristics, inferring that homeopathy has elements of efficacy through consensus (Horton-Salway 2001).

Another point to note is that NS’s claim, ‘I found a remedy that would stop ear infections instantly’ (Line 10) (extraordinary Y), interrupts the flow of the narrative by drawing upon the device of narrative reflexivity. The purpose of narrative reflexivity is to draw the listener to the relevance of the prior items whilst assessing

their significance. Auburn (2005) identified this device in narratives produced by offenders in a prison setting, indicating the ways in which offenders shift from past to current contexts during their narratives as a way of proportioning blame. Here, NS formulates a past event to evaluate it in the present account (the here and now), to further work up the factuality, authenticity and credibility of the narrative by justifying and promoting elements of efficacy. Essentially, NS's 'extraordinary' claim is the prime focus of evaluation and the one that determines the story's endpoint (Linde 1993).

A final analytical point is that NS works up attributions of 'I'll tell you how I came to homeopathy' due to the apparent limitations of medicine. At the same time, he works up an everyday event (mundane X)—'he had constant ear infections one winter' (Line 6)—contrasted with an exceptional result (extraordinary Y)—'...I found a remedy that would stop ear infections instantly' (Line 10)—as a way of adding credibility, persuasiveness and an 'extraordinary' value to the overall account. Although NS talks up and boosts the credibility of homeopathy by the use of various rhetorical devices, the wider effect of NS's account is to orient to homeopathic practice as a 'last-resort-form' and 'type' of practice. This way of presenting has inevitable wider implications if considered from a 'top-down' perspective (which I discuss further at the end of the chapter).

Extract 6:7

1. CC: could you tell me something about yourself
2. D: ...well I (.) came in to homeopathy from research in genetics I had
3. done toxicology before that (.) very orthodox at university and thus
4. through the ((name of establishment)) hospital I worked in (.) but my
5. husband had been using homeopathy for a long time and it put me off
6. because of a great big black text book and I'd been studying for so
7. long and I thought I don't want to know about (.) that (.) but it got to
8. the point that you realise orthodox medicine has very little to offer and
9. homeopathy produced great results (.) really

In Extract 6:7, in a defensive orientation to enhance the credibility of her practice, D (the interviewee) presents evidence in relation to the claim that she ‘came into homeopathy from research in genetics’ (Line 2) with the apparent realisation that orthodox medicine has very little to offer. By making an explicit reference to the limitations of medicine and medical practices, D is critical of medical orthodoxy. Mainstream practices such as ‘genetics’ (Line 2), ‘toxicology’ (Line 3), and ‘orthodox medicine’ (Line 8) are constructed and presented as relevant medical experiences, and referring to them is how D makes her talk relevant as a reliable information source to substantiate the claims made. D’s interest in homeopathy is implicitly attributed to the criticisms and apparent failures and disappointments of medicine. In so doing, D is observed to be *boosting-the-credibility-of-homeopathy* by invoking apparently extraordinary results through deploying the (mundane) ‘X’ then (extraordinary) ‘Y’ device (Jefferson 1984; Wooffitt 1992). On the downside, the effect of D’s strategy is to discursively structure homeopathy as a ‘last-resort-form’ and ‘type’ of practice when negotiated and produced through an apparent semi-biographical account.

In response to CC’s request, ‘could you tell me something about yourself’ (Line 1), D—without CC referring to homeopathy in his request—makes explicit as relevant to the interaction, ‘well I came in to homeopathy from research in genetics I had done toxicology before that (.) very orthodox at university and thus through the ((name)) hospital I worked in’ (Lines 2-4).

D’s immediate response is in alignment with a professional context designed to emphasise homeopathy as a practice apparently secondary and alternative to research in genetics, toxicology and orthodox practice ‘at university and the ((name of establishment)) hospital’ (Lines 3-4). More than this, the inferences suggest that D has

a diverse and high level of medical knowledge. Significantly, although D is working up evocative claims, there is no reference to looking to homeopathy for the possible benefits it may offer. From lines 2 to 10, D orients to the (mundane) ‘X’ component of the ‘X then Y’ device as a way of talking up how she looked to homeopathy. On the downside, homeopathy is presented as a ‘last-resort-form’ and ‘type’ of practice on this basis.

D follows this with ‘but my husband had been using homeopathy for a long time and it put me off because of a great big black text book’ (Lines 4-6). This can be heard as the deployment of consensus and corroboration. Consensus and corroboration act as a function that is used to make a greater factual implication. It blends in with the normativity of the event by attempting to confirm and construct a more solid, factual consequence into the account (Horton-Salway 2001). D’s corroboratory use of ‘the other’ as a discursive device—specifically ‘my husband...’ (Lines 4-5), followed by the relevant consensual features, ‘had been using homeopathy...’ (Line 5)—bolsters the factuality and authenticity of her argument. The category of ‘husband’ (Line 5) suggests that D’s opinion can be trusted, as the category entitlements associated with ‘husband’ (Line 5) in this context infers that D was close at hand to know about homeopathy due to her close relationship. Additionally, by claiming ‘it put me off because of a great big black text book’ (Lines 5-6) and ‘I thought I don’t want to know about that’ (Line 7), D is ‘doing’ stake inoculation to offset a possible challenge around issues of self-interest and is one way of attending to the responsibility of her personal accountability to counter any potential accusations of bias towards homeopathy. More than this, the ‘great big black text book’ (Line 6) displays the objectivity of the inference being made, suggesting that the book was potentially discouraging. Additionally, D’s ‘I don’t want to know

about that' (Line 7) is an explicit refutation to play down prior notions of any personal vested interest in promoting homeopathy (Potter 1996).

A further analytical observation can be made about the way that D constructs a further mundane context and produces a good example of the X'' component of the 'X then Y' device (Wooffitt 1992). D claims that 'I'd been studying for so long I thought I don't want to know about that' (Lines 6-7)—inferring that D is portraying a lack of a vested interest in homeopathy—while 'it got to the point that you realise orthodox medicine has very little to offer' (Lines 7-8) suggests that 'orthodox medicine' (Line 8) was in some way problematic, which could also be heard as offsetting any potential challenge from CC if the account was heard to promote homeopathy or D's self-interest.

There is a contingent relationship between D and the final formulation 'I don't want to know about that but it got to the point' (Lines 7-8), suggesting that D is reporting the kind of event any neutral, competent observer would have experienced, and is thus potentially fishing for the entitlements in alignment with the category of 'ordinary person' 'doing ordinary things' (Sacks 1992; Stokoe and Hepburn 2005). Here, the effect is such that D, the speaker, portrays the normativity of an everyday event by emphasising the ordinariness of her actions: 'I'd been studying for so long...' (Lines 6-7) and 'but it got to the point...' (Lines 7-8). In doing so, D displays the event as routine, bland and commonplace. Immediately following this, D makes explicit 'and homeopathy produced great results (.) really' (Lines 8-9)—the (extraordinary) 'Y' component of the discursive structure in play.

On this occasion, D's talk works to bolster the credibility of homeopathy: 'homeopathy produced great results (.) really'. D accomplishes this by offsetting attributional inferences about her own potentially biased description in order to

promote the externality of the event as something any neutral, competent observer would witness in a similar situation (Wooffitt 1992). However, drawing upon this discursive device indicates to the listener that the phenomenon is possibly highly controversial, contentious and a contestable knowledge claim. Significantly, in the segment of talk immediately before the 'X then Y' device, D invokes a range of attributes to indicate the potential of her self-interestedness.

Finally, D works up her account to make explicit that she apparently looked to homeopathy largely due to the criticisms, limitations and possible disappointments of medicine, and at the same time is implicitly attributing these inferences to promote homeopathy as a credible treatment option. D is explicitly offering her view that homeopathy is a viable alternative. She works up her own individual credibility as someone with a broad medical expertise, thereby suggesting that her views are relevant when discussing homeopathic and mainstream medical practices. Although this is potentially positive and can be heard to boost the credibility of homeopathy, there is the contradiction of positioning homeopathic practice as a 'last-resort-form' and 'type' of practice. D's description adopts a comparative frame that compares the category 'homeopathy' with discursive resources drawn from conventional medicine, i.e. genetics, toxicology and orthodox medicine. D reproduces them as the taken-for-granted yardstick by which to measure practice, suggesting that they acquire a degree of permanence and continuity, thus making homeopathy a downgraded alternative to conventional medical practices in research interview talk about homeopathy.

Extract 6:8

1. CC: could you describe some of your reasons for getting interested in
2. homeopathy
3. DH: hm mm (.) well I wasn't interested in homeopathy when I started in
4. the ((name of establishment)) =
5. CC: = so why ((inaudible))
6. DH: I was interested in a easy job that would allow me to finish ehh (.)
7. ehh finish a degree course that I was doing outside medicine and ehh
8. (.) so I went to the ((name of establishment)) for all the wrong reasons
9. and I wasn't entirely convinced about the value of homeopathy on the
10. onset of that job either (.) what gradually I became aware of was (.) a
11. change in the ethos a change in the approach ehh (.) hmm a change in
12. the fact that the emphasis the different people put on the person rather
13. than all the various diagnostic labels

Now consider Extract 6:8. Through primarily a defensive orientation of his practices, DH (the interviewee) works to enhance the credibility of his own individual practices and attends to issues concerning his personal accountability to counter any potential challenge to the contentiousness of the claims being made. Although DH can be heard in his construction initially to be undermining homeopathic practice through a 'troubles telling' talk, at the same time he is observed to be boosting the credibility of homeopathy by working up and identifying perceived humanistic qualities attached to homeopathic practices, of which he was apparently previously unaware (Jefferson 1984; Jefferson and Lee 1992).

DH's account is constructed in a before-and-after formulation, with DH claiming at the outset, 'I wasn't interested in homeopathy' (Line 3), followed by 'what I gradually became aware of was a change' (Line 10). In so doing, homeopathy is presented as a 'last-resort-form' and alternative 'type' of practice, looked to as a potentially easy option when contrasted with notions of mainstream medicine. On this basis, DH can be observed to draw on the formulation, 'At first I thought ... (mundane X) ... but then I realised... (extraordinary Y)' (Jefferson 1984b; Wooffitt

1992). This is how DH constitutes factuality, objectivity and credibility into the claims being made, while at the same time he is observed to be boosting the credibility of homeopathy. In doing so, homeopathy is portrayed as having potential benefits, but with the downside of being presented in a culture of scepticism as a controversial and contested knowledge claim.

In a response to CC's request, 'could you describe some of your reasons for getting interested in homeopathy' (Line 1), DH immediately makes relevant the interaction, 'well I wasn't interested in homeopathy when I started in the ((name of establishment))' (Lines 3-4) as a potential and explicit rebuttal. This signals to the listener that DH had previously been possibly sceptical of homeopathy, which exhibits the (mundane) 'X' part of the 'X then Y' device. The rhetorical function is to draw attention to the fact that he (DH) had no prior interest in, or reason to promote, homeopathy. DH can also be observed to be attending to the risk of stake and interest in his account; DH's stake inoculation of 'I wasn't interested' (Line 3) is how he attends to and manages to counter the possible challenge that he is someone who could benefit from promoting homeopathy (Potter 1996).

DH furthers this inference by claiming 'I was interested in an easy job that would allow me to finish ehh (.) ehh (.) finish a degree course outside of medicine' (Lines 6-7) as a way of justifying his practice. This displays a defensive orientation to substantiate the inferential dimensions to the issue of his interest in taking an easy job to complete a degree course outside of medicine. This is followed with the claim, 'so I went to ((name of establishment)) for all the wrong reasons' (Line 8), which portrays and warrants the objectivity of the event and at the same time implicitly downplays the interest in homeopathy. DH's explicit claim, 'for all the wrong reasons' (Line 8),

emphasises his apparent prior expectations of homeopathy before experiencing it, which adds authenticity and establishes the facticity of the event.

Following this, DH offers, ‘I wasn’t entirely convinced about the value of homeopathy on the onset of that job either’ (Lines 9-10), which provides a further portrayal of potential doubt or prevailing scepticism that is heard to downgrade his expectations of the benefits of homeopathy. By invoking potentially negative attributes relevant for consideration, DH can be heard in this instance to undermine homeopathic practice. DH thus constitutes homeopathic practice as something he initially found insignificant. This has the effect of reducing the notion of promoting self-interest and involvement. Rather, it is what any neutral, competent observer would observe in a similar position, and is a way of building up facticity and authenticity for the claims being made (Pollner 1987; Potter 1996).

In the context of the (extraordinary) ‘Y’ part of the ‘X then Y’ device, DH works to construct further credibility as a competent and reliable speaker, claiming ‘what gradually I became aware of was’ (Line 10), which is heard by the listener as an introduction to talk up and promote a perceptual change in relation to homeopathic practices. DH achieves this by invoking apparently humanistic traits—‘a change in the ethos a change in the approach ehh (.) hmm a change in the fact that the emphasis the different people put on the person’ (Lines 10-12)—that are attributed to homeopathic practice, and by his apparent empirical factual knowledge of what he subsequently witnessed. By stating ‘rather than all the various diagnostic labels’ (Lines 12-13), DH contrasts this medically oriented utterance with homeopathic practices, inferring that ‘various diagnostic labels’ (Line 13) are attributed to the notion of medical disease in opposition to the apparently humanistic attributes in the segment of the account immediately prior to this.

The three different parts of this segment of DH's account are all emphasised by the repetition of the discursive resource, 'a change' (Line 11), which infers that there was a fundamental shift in a previously perceptual experience, and which is part of building objectivity into the claim being made. It is how DH attends to the (extraordinary) 'Y' component of the 'X then Y' device. The orientation to the three-partedness structure demonstrates a list of dimensions in the way homeopathy views the individual—namely, 'change in the ethos' (Line 11) and 'change in the fact that the emphasis the different people put on the person...' (Lines 11-12)—that display a range of humanistic qualities and the different sorts of actions that are attributes of the shift apparent in DH's apparent cognitive change. DH can be observed to be attending to the responsibility for his personal accountability by reporting his initial awareness of the apparently humanistic phenomenon, and to be strengthening the argument via a three-part-listing form (Jefferson 1990).

Finally, by accounting in this way, DH's strategy is used as evidence to infer that his interest in homeopathy (and subsequent practice of homeopathy) was attributed to the events described above. In this way, DH as a speaker accomplishes factuality, authenticity and credibility through invoking various discursive devices to add persuasiveness. At the same time, DH produces a specific strategy where he is observed to be boosting the credibility of homeopathy. The (mundane) 'X' then (extraordinary) 'Y' is one way of designing his account to achieve such an effect. The potential downside to this way of accounting is that it constitutes homeopathy as a problematic 'last-resort-form' and 'type' of practice. With a formulation like this, DH talked up the persuasiveness of his overall argument as everyday objective experience, not solely contingent to his own individual human agency, and building facticity and authenticity into the claims being made

6.3.2 ‘Doing being Ordinary’: Practitioners in Extracts 6.6 -6.8

Another interesting feature of the way NS, D and DH present their claims is in the way they work to boost the credibility of homeopathy by providing empirical evidence in a before/after formulation. These participants are not presenting as promoting contentious or controversial information, but merely reasonable neutral competent observers passing on the usualness of facts as they are. In other words, they are ‘doing being ordinary’ as a way of building personal credibility as reliable speakers or as ‘ordinary people doing ordinary things’ (Sacks 1992; Stokoe and Hepburn 2005)—in this instance as credible practitioners providing mundane descriptions of how they look to and manage their delicate and sensitive homeopathic practices.

6.3.3 Practitioners Undermining Potential Criticisms

In the following Extracts 6:9-6:12, through defensive orientations the interviewees primarily undermine potential criticisms and draw on various discursive devices as a way of boosting the credibility of homeopathy, as seen below:

Extract 6:9

1. CC: what is homeopathy
2. VA: ...for me there is a real spiritual side to homeopathy which is often
3. also neglected because people are worried that if they start mentioning
4. that it won't be accepted by mainstream science (.) which in my mind
5. is totally not true because I know many many doctors and many (.)
6. many scientists whom do go to church on Sundays and their religious
7. life is very important to them (.) it's just that they don't bring it into
8. their daily life when with homeopathy (.) in homeopathy you can't
9. weigh and measure the medicine either (.) y'know it's not there

The first point to note in Extract 6:9, in the context of the research interview, is that VA's (the interviewee) strategy functions to enhance the credibility of her practice. The account does, however, highlight potential difficulties that VA has in making homeopathic practice credible. For instance, VA claims that 'a real spiritual side to homeopathy' (Line 2) is disregarded, and is presented as unfairly judged, criticised and discredited by 'mainstream science' (Line 4). However, through a 'troubles telling' sequence, VA works to construct a case by defending 'a spiritual side to homeopathy' (Line 2). In so doing, VA undermines the potential criticisms 'that it won't be accepted by mainstream science' (Line 4) by suggesting that numerous 'doctors' (Line 5) and 'scientists' (Line 6) have a 'religious life' (Lines 6-7) on a 'Sunday' but apparently not in 'daily' life' (Line 8) when in relation to homeopathy. In accounting this way, VA is orienting to boost the credibility of homeopathy strategy. Although VA's strategy is presented as a factual, credible and persuasive defence of her practice, the potential downside is to locate homeopathy as a contested and controversial practice, which has significant implications with regards to potential and continual marginalisation.

In VA's response to CC's request, 'what is homeopathy' (Line 1), she claims 'for me there is a real spiritual side to homeopathy' (Line 2) as a possible assessment relevant to the interaction. The reference to 'real spiritual side' (Line 2) introduces an almost religious orientation vis-à-vis 'homeopathy' in her description. VA works up this claim as a potential taboo area with a direct contrast to medicine with 'people are worried if they start mentioning that it won't be accepted by mainstream science' (Lines 3-4). A function of this particular way of accounting is to be heard as a potential criticism from mainstream science directed at homeopathy, and that in doing so presents it in a culture of scepticism. Moreover, VA's use of 'mainstream science'

(Line 4) suggests that it is the taken-for-granted benchmark by which to evaluate and judge homeopathic practice. The use of the vague terms ‘people’ (Line 3) and ‘they’ (Line 3) in relation to presumably a group of homeopaths rhetorically provides enough sustainable objective evidence for the account without providing an accurate descriptive portrayal. More than this, these terms can be deployed to work up corroboration, objectivity and factuality to the potentially damaging inferences being made (Edwards and Potter 1992; Horton-Salway 2001; Wooffitt 1992).

Following this, VA immediately and spontaneously invokes ‘many many doctors and many (.) many scientists whom do go to church on Sundays’ (Lines 5-6), which can be heard as a description of the vast quantity of ‘doctors’ (Line 5) and ‘scientists’ (Line 6), and suggests that aspects of spirituality are acceptable and right behaviour in specific contexts—namely ‘church on Sundays’ (Line 6). The repetition of ‘many many...’ (Line 5) can be heard as an extreme-case formulation drawn upon to make VA’s description more credible and persuasive by focusing on the extreme elements of judgement (Pomerantz 1986). VA’s ‘many many’ (Line 5) infers that if it is acceptable for ‘doctors’ (Line 5) and ‘scientists’ (Line 6) to ‘go to church on Sundays’ (Line 6), then there is a legitimate case for ‘a spiritual side to homeopathy’ (Line 2) and subsequently for VA’s own practice. In doing so, VA offers a way to justify and legitimise her own practice by contrasting it with notions of mainstream medical practice—implicitly inferring there is nothing unusual or potentially marginal about homeopathic practice.

VA makes explicit the defence that ‘doctors’ (Line 5) and ‘scientists’ (Line 6) also have a ‘religious life’ (Lines 6-7), which is followed immediately with the claim: ‘it’s just that they don’t bring it into their daily life when with homeopathy’ (Lines 7-8). The effect of such inferences is that on this basis VA’s practice should not be

viewed as irregular but as in alignment with what both ‘doctors’ (Line 5) and ‘scientists’ (Line 6) do. To further bolster VA’s practice, ‘doctors’ (Line 5) and ‘scientists’ (Line 6) can be heard as adding consensus and corroboration to the inferences being made in order to work up, produce and transform the portrayal into a more solid, factual, believable and credible version of events (Horton-Salway 2001; Wooffitt 1992). In this way, VA manages a defence to counter the possibility of being challenged on issues of her responsibility to personal accountability of her practices. The deployment of ‘just’ (Line 7) by VA on this occasion is the ‘deprecatory meaning’ that functions to express an attitude by minimising and downplaying the significance of people bringing their religious life into homeopathy (Lee 1987). Note how VA provides further evidence as a way of justifying a spiritual side to homeopathy by stating, ‘in homeopathy you can’t weigh and measure the medicine either (.) y’know it’s not there’ (Lines 8-9), which works as a prospective defence to counter potential challenges regarding the legitimacy of the claims being made.

In summary, VA spontaneously defends her own individual practice by undermining a potential criticism, namely that ‘it (homeopathy) won’t be accepted by mainstream science’ (Line 4). However, at the same time VA’s construction functions to boost the credibility of homeopathy and her own individual practice by undermining potential criticisms and seeking the approval of doctors and scientists. The drawback is that homeopathy is presented as a contested, controversial and troubled practice located in a culture of scepticism and is only offered as credible when boosted by seeking the approval of ‘doctors’ (Line 5) and ‘scientists’ (Line 6). In doing so, homeopathic practice is worked up as an alternative, contentious ‘type’ of practice positioned on the fringe of the mainstream.

Extract 6:10

1. CC: is there anything else you'd like to tell me about homeopathy
2. HP: ehh (.) the other thing is there is considerable hostility to
3. homeopathy ehh mm (.) by people who either don't understand it (.) or
4. are hostile because they badly need to fit it into a structure and they
5. haven't got that structure they ehh (.) say it's not scientific well it's
6. just as scientific as other sorts of medicine there is nothing not
7. scientific about it

First, in Extract 6:10, HP's (the interviewee) strategy functions to enhance the credibility of her practice. HP achieves this by negotiating, defending and arguing through a 'trouble telling' sequence by talking up the apparent 'hostility' (Line 2) directed towards 'homeopathy'. HP constructs a case to claim that homeopathy is 'just as scientific as other sorts of medicine' (Line 6). At the same time, HP presents her account as solid, factual and credible evidence. Moreover, HP's inferences are designed to discount, counter and challenge potential criticism, and at the same time are a way of attending to and managing issues in relation to personal accountability—to promote and defend her claims as unbiased and credible. As a discursive accomplishment, HP is observed to be boosting the credibility of homeopathy and subsequently her own individual practices. The possible downside to accounting in this way is that HP talks up homeopathy as contested, controversial and troubled 'type' of practice and as a contentious knowledge claim.

CC's utterance, 'is there anything else you'd like to tell me about homeopathy' (Line 1), can be heard as an open invitation that offers HP the opportunity to respond in a specific way when discussing homeopathic practices. In her response, HP—without any explicit reference in the request from CC—attributes potentially negative characteristics to homeopathy, stating that 'the other thing is there is considerable hostility to homeopathy' (Lines 2-3), which can be heard as homeopathy receiving criticisms. HP portrays 'considerable' (Line 2) as a valid description of the amount of hostility. This can be heard as a way that 'considerable' (Line 2) emphasises the frequency of the apparently excessive amount of hostility attributed to 'homeopathy'.

This is followed by HP working up what is heard as further criticisms in the face of the large quantity of unreasonable and unacceptable hostility attributed to homeopathy by the unspecific people. HP provides 'by people who either don't understand it (.) or are hostile because they badly need to fit it into a structure and

they haven't got that structure' (Lines 3-5) as potential and explicit criticisms that suggest homeopathy is in some way viewed as sceptical, problematic and troubled. In doing so, HP deploys this to be heard as providing evidence to support the injustice of the inferences. By describing potentially negative attributions in alignment with homeopathic practices—'people either don't understand it (.) or are hostile because they badly need to fit it into a structure and they haven't got that structure' (Lines 3-5)—HP's claims can be heard as deploying mundanely acceptable descriptions that are worked up and corroborated ('by people' (Line 3)) to give the effect of being what any neutral, competent observer would describe, so that the claim appears to be a prevailing and commonplace assumption in relation to homeopathy (Horton-Salway 2001; Pollner 1987; Potter 1996).

As a way of building up further credibility, facticity and objectivity into the account, HP deploys the discursive device of consensus and collaboration by using the words 'by people' (Line 3) and 'they ehh (.) say' (Line 5). This establishes aspects of objectivity by showing that different people have experienced or are aware of the phenomena to which HP refers. In addition, it establishes consensus regarding the claims and inferences being made (Wooffitt 1992; Horton-Salway 2001). Goffman's (1981) notion of footing can be observed as HP manages neutrality or impartiality in this segment of speech; HP's deployment of 'people' (Line 3) and 'they' (Line 4) is heard as passing on contentious information on someone else's behalf. HP makes explicit potentially negative attributes in relation to 'people' (Line 3)—albeit she is implicit in inferring who the 'people' (Line 3) actually are.

Additionally, the notion of 'footing' demonstrates the indexical, reflexive and fluctuating character of frames—'they ehh (.) say it's not scientific' (Line 5) identifies how HP shifts from one to the other to create authenticity and factuality for her claims. This infers that HP is merely passing on potentially controversial information but, at the same time, she is attending to and managing issues in relation to her own personal accountability. Taking the position of a neutral, competent observer, HP offers 'people' (Line 3) and 'they ehh (.) say' (Line 5) as the sources of the attributes, which adds strength to the neutrality and authenticity of the apparent criticisms made.

The authenticity of HP's account is furnished further with a potentially negative attribute—'they ehh (.) say it's not scientific' (Line 5) draws upon the discursive device of an active voice. The active voice on this occasion suggests that other people might experience the same thing, reinforcing the objectivity and

factuality of the declaration. The utterance is designed as if HP previously heard it from ‘they’ (Line 5) and in exactly those words (Potter 1996; Wooffitt 1992). This is followed by a defensive orientation: ‘well it’s just as scientific as other sorts of medicine there is nothing not scientific about it’ (Lines 5-7). This suggests that there is a scientific basis for homeopathy. By invoking ‘just’ (Line 5) here, HP is deploying it in its ‘restrictive meaning’ context, which functions to portray the idea of limitation; on this occasion, ‘just’ (Line 5) restricts the notion of homeopathy to equate it with being as scientific as ‘other sorts’ (Line 6) of medicine (Lee 1987).

A final observation is that in her defence of homeopathy and her everyday practices HP does two things; she not only undermines potential criticisms and boosts the credibility of homeopathy but she also works to enhance her practice as credible.

In this way, HP continually displays the controversial and contested knowledge properties of her practices when making claims in a medical/homeopathy contrast structure.

Extract 6:11

1. CC: is there anything you would like to add about homeopathy that hasn’t
2. been touched upon
3. G: I think (.) if there was one thing I would wish for is that there was
4. more moderate (.) ehh positive media (.) ehh mhm coverage of
5. homeopathy (.) I think of all the therapies it gets the rawest deal (.) ehh
6. probably the worst coverage (.) and it’s because people don’t
7. understand it and I think people don’t understand it because (.) it tends
8. to try (.) people try to explain it in an allopathic model ((conventional
9. medicine)) where they tend to go to the wrong people for explanations
10. (.) there there was a programme on not long ago about the mm (.) hmm
11. (.) the horizon thing

The first analytical point to note in Extract 6:11 is that G’s (the interviewee) strategy is presented through invoking various social actions in such a way as to enhance the credibility of her practice. Her accounting sequence is structured in a three-part-list format through a ‘troubles telling’ sequence, which can be heard to constitute potentially negative attributes regarding media coverage of homeopathy. Each part of the list begins with ‘I think’ (Lines 3, 5 and 7), and in this way HP provides potential assessments of current homeopathic practices.

The attributional business is designed to defend and justify her homeopathic practice in relation to the apparently unjust and critically negative media coverage. G builds a defence case for homeopathy by claiming that it is misunderstood—she suggests that homeopathy ‘gets the rawest deal’ (Line 5) and ‘probably the worst media coverage’ (Line 6). In portraying events in this way, G talks up what can be heard as unfair accusations in relation to homeopathic practice. This is further reinforced with explicit claims—‘because people don’t understand it’ (Lines 6-7), which is attributed to consulting ‘the wrong people for explanations’ (Line 9) in relation to the ‘allopathic model’ (Line 8)—being presented as an evaluative resource and a way of emphasising the potential limitations of people’s views. G refers to the ‘horizon thing’ (Line 11) as an explicit example of an apparent source of the ‘rawest deal’ (Line 5) and ‘worst coverage’ (Line 6). As a discursive accomplishment, G is working to undermine potential criticisms as a way of boosting the credibility of homeopathy. But by doing so, HP presents homeopathy as a controversial and contested practice on the margins of the mainstream.

The request from CC is framed in such a way as to elicit either a positive or negative response from G: ‘is there anything you would like to add about homeopathy that hasn’t been touched upon’ (Lines 1-2). Accordingly, G responds immediately with, ‘I think (.) if there was one thing I would wish for is that there was more moderate (.) ehh positive media (.) ehh mhm coverage of homeopathy’ (Lines 3-5)—an assessment and a potentially negative view which suggests that bias exists in relation to homeopathy.

This is followed by G making relevant within the interaction, ‘I think of all the therapies it gets the rawest deal (.) ehh probably the worst coverage (.) and it’s because people don’t understand it...’ (Lines 5-7). This is presented as potential

criticism directed at sceptics of homeopathic practices. Moreover, it implies that homeopathy is possibly unfairly discriminated against by the media. G identifies the ‘rawest deal’ (Line 5) and ‘worst coverage’ (Line 6) in reference to the level of apparent adversarial injustice that homeopathy receives from the media. The effect of G’s description is to emphasise—by way of an extreme-case formulation—the extent of the negative attention from the media in order to maximise the credible and persuasive value of her claim. In so doing, G is justifying her proposition that homeopathy is being grossly and unfairly treated by the media and, on this basis, it is an extreme-case formulation, there to add persuasiveness to the inferences made (Pomerantz 1986).

G’s next claim, ‘I think people don’t understand it’ (Line 7), is bolstered by a potential criticism: ‘because (.) it tends to try (.) people try to explain it in an allopathic model ((conventional medicine)) (Lines 6-9)’. G is attributing the non-specific category of ‘people’ (Line 7) to those who do not understand homeopathy—invoking ‘people don’t understand it’ (also previous paragraph lines 6-7) and ‘I think people don’t understand it’ (Line 7) as a way of adding corroborative evidence and building up the factuality of the claims being made (Horton-Salway 2001; Wooffitt 1992). Taken in this context, the repetition of the claims is noteworthy and can be heard to add consensual and corroborative evidence to the factual details. In alignment with this attribution, corroboration as a device is produced by emphasising ‘people’ (Line 7); ‘people try to explain it in an allopathic model’ (Line 8) is evidence that different ‘people’ (Line 7) have the same portrayed consensus as G. Accordingly, the discursive device of consensus and corroboration makes it difficult to challenge G’s personal accountability, in terms of the claims made, on the grounds of factuality,

authenticity and credibility, because she is attending to and constituting as merely reporting what ‘others’ have said (Potter 1996; Horton-Salway 2001; Wooffitt 1992).

What is heard is G undermining a potential criticism: ‘where they tend to go to the wrong people for explanations (.) there there was a programme on not long ago about the mm (.) hmm (.) the horizon thing’ (Lines 9-11). This works to proportion potential criticisms in relation to ‘a programme’—namely, ‘the horizon thing’.

Viewing G’s strategy as a series of social actions, she is observed to be undermining potential criticisms and defending homeopathic practice. As a discursive accomplishment, G’s strategy works to boost the credibility of homeopathy and her own individual practice. On the downside, G locates homeopathic practice in a culture of scepticism, suggesting that G has difficulty in persuading the hearer of its merits.

Extract 6:12

1. CC: oh (.) who thinks that if they are seen to be dabbling with anything like
2. this ((referring to homeopathy)) it might skew their (.) career
3. AA: so if you meet for instance I met Sir James Black who was the Nobel
4. Prize winner the chap who found the H2 Antagonist and (.) he was
5. pretty open about itthe trouble is the guys who are on the way up
6. the ladder I had a friend (.) colleague who is I don’t know a professor
7. (.) ehh, (.) now and he said he’d done an experiment which was of
8. homeopathic dilutions which had worked but he was not going to put it
9. on his CV (.) cos (.) he didn’t want to endanger his medical career
10. CC: yeah (.) hmm =
11. AA: = that tells you everything doesn’t it

In the final Extract, 6:12, AA (the interviewee) talks about homeopathy, with an emphasis on enhancing her individual credibility. AA’s strategy functions to boost the credibility of homeopathy. Presented in a defensive orientation, AA works to defend what can be heard as potential criticisms in relation to an ‘friend/colleague/professor’, (Line 6) who apparently acknowledged elements of efficacy with regards to experimenting with ‘homeopathic dilutions’ (Line 8).

However, her strategy has potentially negative effects in that homeopathy is presented in a culture of scepticism as a controversial and contested form of practice. The downside of AA's construction is that aligning his practices with homeopathy would apparently have discredited her 'friend/colleague/professor's reputation. This kind of statement undoubtedly has wider implications in the broader social arena of mainstream medicine. AA makes relevant a possible warning—if 'an experiment which was of homeopathic dilutions' (Lines 7-8) was on 'his CV' (Line 9)—that direct association with homeopathic practices could jeopardise his career aspirations. More than this, by talking up a successful experiment in homeopathy and boosting the credibility of homeopathy in this way, AA presents homeopathy as a practice with considerable problematic and troubled elements.

The request from CC is formulated and framed to infer that dabbling with homeopathy may be detrimental to career aspirations: 'oh (.) who thinks that if they are seen to be dabbling with anything like this ((referring to homeopathy)) it might skew their (.) career' (Lines 1-2). More than this, by invoking the notion of 'dabbling' (Line 1), CC's request indicates that there is a potential superficiality to practising homeopathy.

In a direct response, AA deploys as relevant for consideration 'so if you meet for instance (.) I met Sir James Black who was the Nobel Prize winner the chap who found the H2 Antagonist and (.) he was pretty open about it' (Lines 3-5) as a way of attending to a positive appraisal. By claiming to have met 'Sir James Black who was the Nobel Prize winner' (Lines 3-4), AA talks up her credibility by aligning her apparent relationship to him. In doing so, AA introduces the discursive device of consensus and corroboration; the inference portrays Sir James Black as a reliable scientist when discussing homeopathic practice and, at the same time, builds

objectivity, consensus and corroboration into the claims being made. After all, he is a ‘Nobel Prize winner the chap who found the H2 Antagonist’ (Lines 3-4), which infers that he has genuine status and credibility as a scientist. AA follows this with ‘he was pretty open about it’ (Lines 4-5), tacitly inferring that the claim represented the view of ‘Sir James Black’ (Line 3). AA’s deployment is thus used as consensus and corroboration for homeopathic practice having genuine and intrinsic qualities, and as evidence that the inferences made are represented as factual and authentic.

This is followed with a critical orientation—‘the trouble is the guys who are on the way up the ladder’ (Lines 5-6)—that highlights its potentially problematic nature, reliant upon the invoking of a mundane account. At the same time, AA can be heard to attribute this notion as a source of contention and an apparent justification for the detrimental effect it has on homeopathic practice. The usefulness to AA of the mundane reporting of this event is that the account achieves the effect of apparently describing what any neutral, competent observer would describe. By inferring impartiality, AA constructs a credible description in the context of the research interview (Potter 1996).

AA again deploys the discursive device of consensus and corroboration when referring to the source of information, specifically making relevant the categories of a ‘friend’ (Line 6) and ‘colleague who is I don’t know a professor’ (Line 6). The ‘categories of ‘friend’ (Line 6) and ‘colleague who is I don’t know a professor’ (Line 6) work to build up reliability for and trust in AA’s evidence and strengthens the objective value of the claims being made. ‘Friend’ (Line 6), colleagues (Line 6) and a ‘professor’ (Line 6) would mundanely be deemed credible and reliable sources, and again AA is building the ‘out-there-ness’ of and attending to the responsibility of her

personal accountability vis-à-vis the claims being made (Horton-Salway 2001; Potter 1996; Wooffitt 1992).

Further, AA claims of the ‘friend/colleague/professor’ (Line 6) that ‘he said’ (Line 7) and ‘he’d done an experiment which was of homeopathic dilutions which had worked’ (Lines 7-8). This makes explicit that AA is merely reporting what the ‘friend/colleague/professor’ (Line 6) has said, which works to buttress overall factuality, reliability, authenticity and persuasiveness. This brings to the fore the notion of footing, as AA is heard to be talking on behalf of the ‘friend/colleague/professor’ (Line 6)—‘he said...’ (Line 7)—which at this time in the account implies a change of alignment from the previous production of speech. AA attends to and manages the current production by adopting the role of the animator who is just passing on the information gathered from the principal ‘friend/colleague/professor’ (Line 6), which maintains the neutrality of AA’s claim and is a way of managing ‘stake and interest’ (Goffman 1981; Potter 1996a). Neutrality is observed also in AA’s use of ‘I don’t know’ (Line 6). Here, AA talks up the reported event in relation to a professor and by invoking ‘I don’t know’ (Line 6) as a further way of attending to the issue of personal accountability and managing ‘stake and interest’ on this occasion (Potter 1996a).

Further, AA makes a potential criticism relevant in relation to the ‘friend/colleague/professor’ (Line 6) who had done a homeopathic experiment that had worked, but ‘he was not going to put it on his CV (.) cos (.) he didn’t want to endanger his medical career’ (Lines 8-9). This suggests that there are, potentially, critically negative consequences from associating with homeopathy. This claim thus distances AA from presenting homeopathy as potentially negative. Rather, it is

portrayed as a credible account of another person's description of the situation, i.e. the 'friend/colleague/professor' (Line 6).

The direct speech from AA in the form of a warning—'he said he'd done an experiment which was of homeopathic dilutions which had worked but he was not going to put it on his CV (.) cos (.) he didn't want to endanger his medical career' (Lines 7-9)—is deployed to undermine potential criticisms directed at homeopathic practice by claiming that homeopathy has potential benefits. More than this, it can be observed as reported speech and corroborates AA's factual claims through the device of active voicing. The deployment of an active voice is a common feature of fact construction, suggesting that other people, if present, may have heard the identical utterance and thereby reinforcing the objectivity of the inference (Wooffitt 1992; Potter 1996). On this occasion, AA's utterance is designed as if it was spoken in this way by the 'friend/colleague/professor' (Line 6) at the time. This is used by AA to build up the credibility and objectivity of the event, making it difficult to challenge due to its objectivity and because the event is being presented as reported evidence. A second function of the active voice deployed by AA is to build up corroborating evidence by reporting an apparent experience of patients in order to suggest greater factual and persuasive implications.

AA's 'that tells you everything doesn't it' (Line 11) can be heard as an extreme-case formulation that is used to justify, legitimise and warrant, in a defensive orientation, the authenticity of her previous claims. The description 'everything' (Line 11) belongs to no issue in particular; rather, as 'everything' (Line 11), it acts as a device in relation to prior utterances and inferences and is an extreme-case formulation. On this occasion, 'everything' (Line 11) is deployed in a defensive orientation to counter challenges to the legitimacy of AA's potential criticisms,

demonstrating the wide range of descriptions and prevalence of this practice (Pomerantz 1986).

A final analytical point is that AA's account is formulated by adopting a contrasting evaluative frame through inferring that homeopathic practices (an experiment which was of homeopathic dilutions) were compared explicitly to 'medical career' (Line 9) aspirations. In this context, homeopathic practices are seen to be potentially detrimental and a somewhat downgraded alternative to mainstream medical practices—although AA does work to undermine the potential criticisms directed at homeopathy by deploying a complex series of actions. At some points, AA can be heard to criticise medicine and, by deploying the 'active voice', the trajectory of her talk is utilised to boost homeopathy. Hence, AA can be heard to counter criticisms by boosting the credibility of homeopathy in everyday talk about the role of her colleague in relation to homeopathic practice.

6.3.4 Summary of the Analysis in Extracts 6.9-6.12

In the above Extracts, the interviewees defended their individual practices by boosting the credibility of homeopathy. The function of the strategy is to enhance the credibility of their practice. In doing so, homeopathy is presented through factual accounts and as a contested and controversial practice located in a culture of scepticism. This suggests that to make their homeopathic practices credible presents discursive difficulties for the interviewees. If the discourse is considered from a 'top-down' perspective, then individual credibility is accomplished through specific constructions of homeopathy that, in a wider socio-political, historical and cultural

context, have the potential to continually marginalise it from mainstream acceptance (Wetherell 1998).

6.4 Discussion

The analyses detailed above are specific to the ‘institutional’ setting of the research interview and relevant to the contested and controversial topic of homeopathy. The status and mobilisation of homeopathic knowledge is an accountability issue for the interviewees and the analysis goes some way to support the claims about the function of their explanations as a way to enhance their personal credibility. Consequently, their credibility as competent practitioners is at stake.

In the context of the research interview, CC’s questions were seen to have a direct effect on the topics of discussion and on how the interviewees responded to and constructed their accounts, which depended on the contingency of the immediate normativity of the interview setting. As anticipated, all the interviewees’ accounts and built-in intersubjective sense-making provided variations through the situated functions they served. The research interview was not treated as a tool to access accurate, truthful and factual accounts. Rather, the interviews are conceptualised as discursive accomplishments to explore the interviewees’ interpretative—discourse, rhetorical and communicative—practices. Moreover, the interview is treated as an important site of verbal interaction in which both the interviewee and researcher contribute to the content, shape and social actions of the talk and broader discourse and the specific performative properties (Edwards and Potter 1992; Wetherell 1998).

A further point to note is that not all the data collected from the separate interviews was included in the final analysis. The rationale being, discourse data tends to be rich therefore a particular discursive feature is identified to justify the broader argument. Essentially, the goal of analysis is to describe the organised trajectory of language use over broad strategies. It is for this reason I place emphasis on the examination of interactional strategies in contrast to a detailed analysis of the sequential context made available during the individual interviews in which they occurred.

Moreover, if all data examples were included and referenced to a even larger corpus of material the practicalities and organisation of such a quantity, would potentially make defining the analytical claims overly problematic.

In accounting for their social practices, and as a way of enhancing personal credibility, the interviewees' constructions can be viewed in the broader context, which is set against and contrasted with notions of mainstream medicine as the taken-for-granted yardstick for practice. In their responses to being asked about their homeopathic practices, mainstream medicine goes largely uncontested as the interviewees reassess, establish and negotiate their accounts in relation to the normative organisational principle (mainstream medicine) in talk about homeopathy, within the proposed analytical scheme discussed above. In so doing, homeopathic practice is warranted on different grounds through the patterns of reoccurring features identified as discursive strategies.

In responses to requests made during the research interview, delicate activations of the above two discursive strategies serve to underpin the interviewees as attentive when they account for their everyday homeopathic practices.

In the first strategy, alignment-with-medicine, practitioners in a defensive orientation of their practices align them with mainstream medicine and criticise the

‘lay homeopath’, who is portrayed as a contested and controversial downgraded alternative in contrast to mainstream medicine.

The interviewees rely on the introduction of particular categories or sets of categories that represent what exists and where the interviewee’s place is within the proposed scheme. Significantly, the use of such categories are spontaneously invoked and not put to them in the preceding questions from CC. They are combined with various discursive devices designed to maximise the factual and persuasive power of the interviewees’ descriptions (Edwards 1991; Edwards and Potter 1992). In so doing, this links to broader socio-political, historical and mutually intelligible culturally shared notions of what is inferred by references to mainstream medicine. By recurrently drawing upon a medical/homeopathic practice dyad presented in a comparative frame, the interviewees sustain homeopathic practice as a downgraded alternative on this historically located basis. When accounting for homeopathic practice, this framework, then, is used to negotiate, defend, justify and legitimise mainstream medicine as the taken-for-granted, mundanely accepted yardstick for practice in the research interview setting.

Similarly, in the second strategy, boosting-the-credibility-of-homeopathy, homeopathic practice becomes presented in a defensive orientation of their practice as something problematic when contrasted with notions of mainstream medical practices. The range of ways in which the interviewees demonstrate this includes using the ‘X then Y’ device (Jefferson 1984; Wooffitt 1992) and through ‘troubles telling’ talk (Jefferson 1984a; Jefferson and Lee 1992) or by undermining potential criticisms, combined with various discursive devices and specific social functions to add objectivity, facticity and persuasiveness to the social actions being performed (Edwards and Potter 1992).

There are parallels with how the interviewees structure their talk about homeopathy compared to how other people are found to talk about their life troubles or paranormal experiences—that is, to present homeopathy as a contested and controversial knowledge claim situated in a culture of scepticism. This informs one about how difficult it is to make homeopathic practice credible. In Extracts 5:6, 5:7 and 5:8 in particular, homeopathy is presented as a ‘last-resort-form’ and ‘type’ of practice, which suggests that credibility is an ongoing issue oriented to in everyday interactive situations. In extracts 6:9-6:12, the interviewees, through defensive orientations, undermine potential criticisms as a way of boosting the credibility of homeopathy.

What is shown here is how the interviewees from a ‘bottom-up’ perspective talk up everyday homeopathic practices that are invoked, mobilised and reworked to achieve specific rhetorical functions, which are wholly dependent on the moment-to-moment rhetorical business at hand. By using the descriptions they do, therefore, the interviewees attend to the credibility of their own individual practices and manage issues in relation to personal accountability concerning the authenticity of the claims and actions being made.

For them, however, individual credibility is accomplished only through specific constructions of homeopathy that orient to it as a sensitive practice, and from a ‘top down’ perspective the effect of the broader discourse in play can be observed to potentially and continually marginalise it in terms of mainstream acceptance. This is achieved by constraints on the vocabulary used to describe homeopathy—contrasting with the range of socio-politically informed expectations that legitimise the ‘power’ or ‘dominance’ associated with mainstream medical practices. Therefore, the broader socio-political, historical and cultural resources made available through their

homeopathy discourse reaffirm a set of mutually intelligible, culturally shared normative expectations about what is acceptable and what is not acceptable medical practices, dependant upon specific categorisations and their contentious relationships within the participants' accounts.

From this perspective, the participants' organisation of language use establishes and reflects wider social practices by positioning homeopathy as marginal to the notion of mainstream medicine by relying on historically informed and alternative opposing ideas about medical practices. Hence, I draw upon the poststructuralist Foucauldian (1980) notion of marginalisation—the 'scientific' institution as a metaphor—to constitute the 'what is and what is not' wider scepticism about homeopathic practice's validity and thus define how homeopathy becomes marginalised through the effect of the discourses in play.

Degrees of marginalisation are present when a dominant majority is at the centre of the legitimisation of the institution—mainstream medical practice with diverse marginalised practices represented at the periphery (homeopathic practice as an 'alternative' type of practice). The boundaries of the institution are defined by 'acceptable practices', which are negotiated, resisted and made relevant by the members' methods of sense-making. The notion of what is an acceptable, taken-for-granted or 'normative practice' is socially constructed and constituted over multiple discourses. In other words, through their talk, participants rely on mutually intelligible culturally shared meanings and expectations when (re-)producing their accounting practices and actions. In so doing, the effect of marginalisation varies between interactional contexts and settings. The findings show that the development, the configurations and continuity of medical discourse as a dominant truth

claim/scientific knowledge/metanarrative is a socio-political, historically informed productions and not solely a socially neutral phenomenon.

Therefore, for the post-structuralist, this normative expectation of homeopathy as an 'alternative' is highlighted for its wider political and social ramifications. That is, homeopathic practice is potentially and continually marginalised in terms of mainstream acceptance when presented in a contrast structure (Wetherell 1998).

Chapter 7

Patients ‘doing’ Criticisms-of-medicine-to-justify-homeopathy and Managing-homeopathy-as-alternative

Here, in the penultimate analytical chapter, ‘patients’, in the context of the research interview, are observed to manage the individual credibility of their homeopathic practices through two broad strategies. In this context, the interviewees’ talk is viewed as institutionally constrained and co-constructed with the researcher. The patterns of interaction exhibit the asking and answering of questions. From this perspective, managing individual credibility is accomplished only through specific ways of accounting that orient to sensitive practices.

First, I discuss the interactional elements of the research interview and show how they are compiled into particular activities, which, are constrained by specific norms and expectations. Second, illustrated is the criticisms-of-medicine-to-justify-homeopathy strategy, where, through potential criticisms, the interviewees describe the failures of mainstream medicine as a way to look to homeopathy. Third, through the managing-homeopathy-as-alternative strategy, the interviewees introduce personal factors that offer homeopathy as a problematic, contested, out-of-the-ordinary, alternative type of practice, and the interviewees account for their individual use of it.

Finally, the findings show that the individuals who use homeopathy are responding with particular social actions in order to counter being viewed as lacking credibility. In talking about homeopathy in this way, the interviewees’ social action *in*

situ works to enhance their own practices as credible and to attend to and manage specific issues in relation to their own accountability.

From a broader and ‘top-down’ perspective, the socio-political, historical and cultural contexts of the interviewees’ discourse is demonstrated as having the effect of potentially and continually marginalising homeopathy—in terms of mainstream acceptance—as a practice looked to only after apparent contested experiences with mainstream medicine.

7.1 Interactional Elements of the Research Interview

The interactional elements of the research interview consist of the researcher’s agenda and analytic ideas suggesting potential contaminated and biased trajectory. Therefore, the normative expectation which underpins interview data is the ‘flood’ of the researcher’s categories and assumptions in this production of social interaction. This is demonstrated to be the case as the researchers’ agenda is nonetheless what is generally talked about.

As a product of social interaction it will exhibit interactional design features showing the participants tacit understandings and expectations in the interview setting. Routinely, however, a researcher is likely to try and structure a interview in the normative order given. The data I had underpinned the structural framework available for interviews (Lynch 2002). However, I did not intend to represent and examine the routine norms and expectations relevant to interview data. For this present study I examined the broad discursive strategies relating to the non-sequentiality within the interview setting (see p 332 for a discussion on the merits of both the research interview and in naturally occurring data). Examples of my approach are explicated below.

7.2. The Criticisms-of-medicine-to-justify-homeopathy Strategy

In this first discursive strategy, seen in Extracts 67:1- 7:8, the interviewees account for and defend their individual practices through ‘lay versions’ of their personal experiences with homeopathic practice. The function of the strategy is to enhance the credibility of the interviewees’ practices to avoid their being viewed negatively for looking to homeopathic treatment. In doing so, the interviewees talk up the facticity of the claims and perform particular social actions as ways of making their accounts and subsequent claims credible. They achieve this through ‘troubles telling’ talk (Jefferson 1984; Jefferson and Lee 1992)—explicitly criticising conventional medical practices by highlighting potential treatment failures or adopting the (mundane) ‘X’ then (extraordinary) ‘Y’ device (Jefferson 1984; Wooffitt 1992). These apparent medical failures provide a basis for looking to a different form of treatment, namely homeopathy. This is observed throughout the extracts below:

Extract 7:1

1. CC: moving on to homeopathy (.) why did you choose to use homeopathy
2. AM: (.) I suppose partly as well my first time with homeopathy I would
3. have to say I came to it through a failure of (.) allopathic medicine to
4. deal with the problem at that time (.) the first time I ever went to
5. homeopathy ehh (.) um for myself

Extract 7:2

1. CC: so (.) moving on to homeopathy (.) why did you choose to use
2. homeopathy
3. TC: it was a while ago initially and it was dissatisfaction with the kind of
4. medical profession in general (.) I had had a specific problem that
5. wasn't getting results on conventional (.) and a friend had
6. recommended a homeopathic practice and I decided to give it a try

The first point of particular note in Extracts 7:1 and 7:2 is that AM (the interviewee) reveals his apparent experiences through a similar strategy to TC (the interviewee). Through defensive orientations of their practices, both speakers produce constructions of their use of homeopathy as attributed to the failure of allopathic/mainstream medicine. Both AM and TC's strategies function to enhance the credibility of their practice. In so doing, they direct potential criticisms to mainstream medical practice and thus homeopathy is talked about as a 'last-resort-form' and 'type' of practice, and its justified use is on this basis.

In Extract 7:1, CC's (the researcher's) utterance, '...why did you choose to use homeopathy' (Line 1) is heard as a request by AM (the interviewee), who responds accordingly and explicitly in a defensive orientation of his practice—'I suppose partly as well my first time with homeopathy I would have to say I came to it through a failure of (.) allopathic medicine to deal with the problem' (Lines 2-3)—that is presented as a potential criticism of medicine. More than this, it infers that AM has the ability to act and decide in a manner of his own choosing. However, the utterance 'the failure of allopathic medicine' (Line 3) is displayed in such a way as to portray that a prior experience with an undesirable outcome had 'happened' to him. By referring to the kind of events that happen to people, AM portrays and warrants the factual status in relation to the 'failure of allopathic medicine' (Line 3) as an objective experience and not solely contingent upon human agency (Wooffitt 1992).

This is followed by AM's potentially vague term regarding an area of concern—'to deal with a problem' (Lines 3-4)—that provides enough information to produce a particular inference that AM had a (medical) condition. By inferring a (medical) problem, AM is heard to have no axe to grind with allopathic medicine and produces an account that is difficult to undermine on the basis of a legitimate complaint attributed to the potential criticism, namely the 'failure of allopathic medicine' (Line 3) (Edwards and Potter 1992). Moreover, the facticity and objectivity of his account serves to manage the responsibility of his personal accountability for the claims being made.

AM reiterates, 'the first time I ever went to homeopathy ehh (.) um for myself' (Lines 4-5), which is constituted to be heard as a justification to emphasise the accuracy of the prior event. Thus the potentially failed encounter is portrayed as being in some way responsible for and attributed to AM's 'first time' (Line 2) experience with homeopathy. By substantiating and justifying his claims in this way, AM's talk is designed to portray homeopathy as a 'last-resort-form' and 'type' of practice that is potentially an alternative to mainstream medical practice. In doing so, AM enhances his own individual practice as credible, attributing his looking to homeopathy to criticisms, failure and disappointments in relation to mainstream medicine.

A similar way of accounting is observed in Extract 7:2, which is again taken from near the beginning of the research interview with TC and CC. TC's strategy functions to enhance her practice as credible. At the same time, TC constructs a factual version of events that infer that homeopathy was a viable treatment option oriented and negotiated towards due to the apparent failure of conventional medical practices. TC contingently produces a reference to a prior experience, which is attributed to looking to homeopathy. The strategy is structured through three separate

and successive items: a potential criticism and failure of, or disenchantment with, (mainstream) medicine; an attribute to a (medical) problem that was not resolved; a claim to use homeopathy. By using three-partedness in this way, and by virtue of their placement in the list, TC provides qualities with reference to a before/after production. These add persuasiveness to the authenticity of the claims being made (Jefferson 1990; Wooffitt 1992). Furthermore, listing these items displays to CC that the inferences are made relevant in a defensive orientation of her practice with criticisms in reference to the medical profession.

CC produces a request: 'moving on to homeopathy (.) why did you choose homeopathy' (Lines 1-2). The speaker's design is to elicit from TC an open-ended response in relation to homeopathy. There is no reference to the medical profession or an orienting towards potentially negative attributes. Accordingly, TC responds with the utterance 'it was a while ago initially' (Line 3), which displays TC's potential way of attending to the responsibility of the accountability of the claim. By orienting to a considerable period in the past, TC plays down the relevance of the detail and indicates the length of time he has been involved with homeopathy. Doing so is a way of adding credibility to the following claims. This is followed by a potential criticism, 'it was dissatisfaction with the kind of medical professional in general' (Lines 3-4), which TC uses to justify her practice. This implies that what happened to TC was a potentially negative experience (Wooffitt 1992).

In this way, TC works up and establishes the description to be heard as a previous experience, particularly by emphasising the objectivity of the event, which is attributed to the 'medical profession' (Line 4) (Edwards and Potter 1992). TC thus proportions criticisms in terms of the 'medical profession' (Line 4) and minimises her own human agency. Significantly, TC's looking to homeopathy was not apparently

offered as a positive treatment option in its own right, but was attributed to her potentially negative ‘dissatisfaction’ (Line 3) with the ‘medical profession’ (Line 4). This is how TC begins to orient to a ‘last-resort-form’ and ‘type’ of practice when accounting about homeopathy.

TC works up further objectivity into the account with a potential criticism—‘I had had a specific problem that wasn’t getting results on conventional’ (Lines 4-5)—implying that conventional (medicine) has limitations. Significantly, it was his first choice of treatment—not homeopathy. This can also be heard to build upon the previous utterances. By attributing ‘a specific problem’ (Line 4) in relation to ‘that wasn’t getting results on conventional’ (Line 5), TC further substantiates the event’s facticity by once again externalising her apparent experience (Potter 1996). Although TC claims that it was a ‘specific problem’ (Line 4), the specific details of the problem are not divulged, making it difficult to undermine her inference about a problem which apparently led her to look to homeopathic treatment.

TC draws on the discursive device of consensus and corroboration as evidence to support and maximise the contingency of the event and of her accounting practices: ‘a friend had recommended a homeopathic practice and I decided to give it a try’ (Lines 5-6). This is used to attribute and warrant the justification of her claim and undermine a possible challenge to her personal accountability in that TC is someone who has self-interest in promoting homeopathy. TC’s ‘a friend’ (Line 5) provides consensus by the friend’s recommendation of a homeopathic practice, while the corroboration is built up with the witness, ‘a friend’ (Line 5). These externalising devices transform the account into a solid, factual and authentic portrayal of events. By claiming ‘I decided to give it [homeopathy] a try’ (Line 6), TC portrays the contingency of making a decision to orient towards homeopathic practice. Moreover,

this works as a way to be heard as a justification to look to homeopathy following the apparent criticisms, failures and limitations attributed to notions of mainstream medicine. Interactionally produced in this way, TC makes a perfectly rational case for looking to homeopathy—irrespective of what she may actually think—that works to enhance her practice as credible on this basis (Edwards 2003).

Extract 7:3

1. CC: so why did you choose to use homeopathy
2. KJ: em (.) because I got fed up going to the GP ehh (.) umm not fed up but
3. more dissatisfied sort of dissatisfaction ehh (.) mm (.) I'd gone to get a
4. problem solved (.) it was a headache that kept recurring and it was
5. lasting for about a month and a half and I was going there is something
6. wrong here it just keeps recurring so what do you think the problem is
7. and he's going don't know and he makes a suggestion do this that and
8. another thing but I'm doing those things and it's still not going away =
9. CC: = and so you used homeopathy
10. KJ: yes (.) and I've continued to use homeopathy ever since

In Extract 7:3, KJ (the interviewee) during her interaction with CC (the researcher) produces potentially negative evidence in the form of potential criticisms concerning the GP. Throughout her strategy, KJ is observed to be criticising the GP and the failure of the unspecified treatment for a recurring headache, which can be heard as a direct attribution in relation to looking to homeopathy. The function of KJ's strategy is to enhance the credibility of her practice. In accounting in a defensive orientation of her practices, KJ constructs a case to talk up homeopathy as a 'last-resort-form' and 'type' of practice oriented to on the basis of potentially problematic personal circumstances experienced with the GP (Jefferson 1984a; Jefferson and Lee 1992).

In response to what is undoubtedly taken as a request from CC, 'so why did you choose to use homeopathy' (Line 1), KJ responds accordingly and explicitly, and as relevant to the interaction, with a criticism in relation to 'going' to the GP, 'because

I got fed up going to the GP' (Line 2). By spontaneously invoking this, KJ can be heard to potentially have an axe to grind with the GP and thus consequently produces inferences to suggest this. Significantly, in this segment of her account KJ is not spontaneously warranting a claim to using homeopathy for potential treatment benefits. Rather, homeopathy is looked to in relation to aspects of disappointment regarding mainstream medical practices.

This is followed immediately with what is heard as a further criticism in the form of a rephrasing and upgrade of her first utterance, 'not fed up but more dissatisfied sort of dissatisfied' (Lines 2-3), which works to soften the prior criticism directed to the GP. However, taken together, KJ's criticisms—'I got fed up' (Line 2), 'more dissatisfaction' (Line 3), and 'sort of dissatisfied' (Line 3)—in relation to the GP are the potentially negative resources made available and worked up as evidence of cognitive knowledge of an apparently undesired psychological experience (Wooffitt 1992).

The account is furnished further with KJ making an apparent justification for visiting the GP, 'I'd gone to get a problem solved (.) it was a headache that kept recurring it was lasting for about a month and a half' (Lines 3-5), which works a further area of contention. In doing so, KJ's talk is designed in a three-part-list format to give a factual impression of a mundane activity constituted as a visit to the GP. The three-partedness on this occasion is employed as a fact-constructing device to emphasise the vividness of the description, which adds to the overall authenticity and credibility of KJ's claim (Jefferson 1990). KJ initially makes relevant her conditions for going to the GP, 'I'd gone to get the problem solved' (Lines 3-4), which implies that she had potential expectations of a positive result. By making explicit the problem, 'it was a headache that kept recurring' (Line 4), KJ displays the frequency

and persistence of the headache as a complaint. More than this, the inferences imply that KJ was the kind of person who takes action to resolve the apparent problem. By making relevant that it was set over a significant period of ‘about a month and a half’ (Line 5), KJ further embellishes the objectivity of the reported event and illustrates the period in which she apparently experienced the discomfort. This also infers that KJ was not hasty in her assessment of undermining the GP and is a way of justifying her subsequent critical actions and for looking to homeopathy.

A further analytical point is observed in the way that KJ constructs detailed information regarding a negotiated sequence between herself and, presumably, the GP. The objectivity of the experience is substantiated, played out and dramatised by the use of active voice(s). On this occasion, the voice of the speaker’s speech is constituted through both the GP and KJ, presumably from a past event in which the two parties were interacting.

Initially KJ invokes her own voice, ‘I was going ...there is something wrong here it just keeps recurring so what do you think the problem is’ (Lines 5-6), as a potential request spoken to the GP. This implies that she experienced the event of confronting the GP with her ‘problem’. The use of ‘just’ (Line 6) on this occasion is in the ‘depreciatory’ context, which functions to minimise the significance of the event by contrasting two processes (Lee 1987). This is followed immediately with the GP’s voice: ‘and he’s going don’t know and he makes a suggestion do this that and another thing’ (Lines 7-8). This is presented as a potential criticism, inferring that KJ received superficial, not specific, advice during a routine interaction. KJ thus works to reinforce the facticity of the events being described (Wooffitt 1992). Next, KJ formulates a further criticism using a disclaimer mimicked in her own voice; ‘...but I’m doing those things and it’s still not going away’ (Line 8), suggesting that she

followed the GP's instructions to no avail. At the same time, the disclaimer wards off potentially obnoxious attributions that might imply she is intentionally not following the GP's advice or has an axe to grind with mainstream medical practices (Hewitt and Stokes 1995).

At this stage in the interaction, CC follows KJ's claims with 'so you used homeopathy' (Line 9) as an upshot of the prior segment of KJ's inferences. The upshot here draws on aspects of the immediate prior talk, which allows KJ to constitute reflexively the character of the preceding talk. It is suggested that 'gists' or 'upshots' are used in three main ways: to preserve, transform or delete aspects of the prior talk (Wooffitt, 1992). Here, CC deploys the upshot to preserve the essential aspects of KJ's prior utterances. At the same time, the issues discussed by KJ are portrayed and transformed into 'so you used homeopathy' (Line 9), which does not invoke the depth of dissatisfaction that KJ characterised. CC's re-characterisation of the problem in this way deletes the frustration aspects of the claims being made. KJ responds accordingly with an attribution to CC's suggestion: 'yes (.) and I've continued to use homeopathy ever since' (Line 10). This is a way of promoting homeopathy and justifies her ongoing involvement with the notion of homeopathy as a form of treatment.

By constructing her factual account in this way, KJ can be observed to be critical of the GP and of the treatment being offered. In doing so, KJ manages her inferences to portray herself with individual credibility in looking to homeopathy. In alignment with the speakers in Extracts 6:1 and 6:2, KJ's accounting of the apparent criticisms and failures of medical practices provides the basis for looking to homeopathic treatment as a 'last-resort-form' and 'type' of practice.

Extract 7:4

1. CC: so what feelings did you get from the homeopath then
2. CL: ...I was like you're not listening to a word I'm saying first of all she
3. gave me Beta Blockers (.) cos she told me it was just my heart racing
4. and I just needed to slow down my heart (.) and I was just like no it's
5. not it's not just my heart racing it's everything else =
6. CC: = uhh (.) mm =
7. CL: = and I just felt I think that was a particularly bad GP to be honest so
8. then I changed GPs and went back to my old GP and he was absolutely
9. fantastic about it but I think when I went to see a homeopath that is
10. what I felt I felt you are actually listening to me and you're actually
11. wanting to help

In Extract 7:4, at the outset CL (the interviewee) is concerned with what can be heard as a criticism in relation to the GP's practice, which is apparently inherently flawed. Through a defensive orientation of her practice, CL claims that the GP did not listen and prescribed 'Beta Blockers' (Line 3). This is set in the contrasting category to the 'homeopath' (Line 9) who is displayed as particularly engaging by listening and apparently wanting to help. In doing so, CL attends to and manages issues in relation to the responsibility of her personal accountability and of her practice by defending looking to homeopathic treatment, which is attributed to the failure of a GP. More than this, CL is observed to be talking up homeopathic practice by suggesting that the homeopath wanted to listen and help. The downside of accounting through this critical contrasting of categories between homeopathy and mainstream medical practices is to construct homeopathic practice as oriented to a 'last-resort-form' and 'type' of practice.

CC's utterance, 'so what feelings did you get from the homeopath then' (Line 1), is designed and framed in such a way to elicit a response from CL concerning a prior event with the homeopath. In misalignment with CC's request, CL responds with a description of her medical condition. She immediately makes relevant in a potential critical orientation; '...I was like you're not listening to a word I'm saying'

(Line 2), and produces the (active) voice of herself as a reported dialogue between her and the GP. The active voice is an inferential activity, which utilises utterances designed so that they are heard as reported speech and as said like that on the occasion. Here, the effect is to build up the objectivity of her claim and the active voice is deployed as corroborative evidence as part of fact construction (Wooffitt 1992). Further, CL's potential criticism, 'you're not listening...' (Line 2), provides an inference to the character of the GP that is possibly offensive to her and attributed to the apparent undesirable behaviour of 'not listening' (Line 2). This is followed by a further potentially contentious aspect: 'first of all she gave me Beta Blockers (.) cos she told me it was just my heart racing and I just needed to slow down my heart' (Lines 2-4). This infers that there was a physiological component to CL's complaint where she possibly disagrees with the GP. Here the first use of 'just' (Line 3) is in the 'restrictive meaning' context, functioning to commit the speaker to the truth of the proposition, and thus proposing a meaning that portrays the idea of limitation to CL's heart racing. The second use of 'just' (Line 4) is in the 'depreciatory' context, which functions to minimise the significance of the process, 'to slow down my heart' (Line 4), when in comparison to the process of CL's 'heart racing' (Line 3) (Lee 1987).

As part of presenting facticity into the account, CL again deploys the active voice of the GP through a potential assessment of her condition, which further portrays the event as objective—'it was just my heart racing and I just needed to slow down my heart' (Lines 3-4)—and infers that the problem with CL was physiologically oriented. The inference gives weight to the claims made by being attributed to the GP and portrayed as what was said on a prior occasion (Wooffitt 1992). Following this, CL is heard to dispute this inference by again deploying an active voice of herself in a prior dialogue with the GP.

To add further authentic and factual properties to the discursive evidence, she formulates a potential rebuttal: 'I was just like no it's not it's not just my heart racing it's everything else' (Lines 4-5). This is constructed to be heard as a defence in relation to the physiologically oriented inference substantiated by the GP. The first use of 'just' (Line 4) is in the 'restrictive meaning' context in the act of offering a suggestion within the idea of limitation to the inferences made. The second use of 'just' (Line 5) is in the 'depreciatory meaning' context, which is used to minimise the significance of the GP's judgment by downplaying and explicitly contrasting 'not just my heart racing' (Line 5) with 'it's everything else' (Line 5) (Lee 1987).

In reporting the immediate and spontaneous deployment of 'it's everything else' (Line 5), CL defends her view of the contrast between the GP's apparent misdiagnosis of the heart racing and 'it's everything else' (Line 5). On this occasion, 'everything' (Line 5) is a tacit description of the quantity of possible options available to the GP and operates to provide the amount of unacceptable options the GP apparently did not recognise. As such, it is heard as an extreme-case formulation. This formulation is designed to add persuasiveness to the claim that the GP's judgment was possibly wholly inappropriate (Pomerantz 1986).

CL then makes explicit, 'I just felt I think that was a particularly bad GP to be honest so then I changed GPs and went back to my old GP and he was absolutely fantastic about it' (Lines 7-9). This can be heard as a contrast of a criticism between an apparently bad GP and the upgrade of a fantastic GP. CL's 'absolutely fantastic' (Lines 8-9) is observed to be the deployment of an extreme-case formulation. Here, CL shifts the emphasis from the agent (CL) to circumstances—the change of GP to the 'old GP' (Line 8), which makes it difficult to challenge as occurring because of personal caprice. The use of 'absolutely fantastic' (Lines 8-9) being attributed to the

GP's approach is observed to be extreme on two counts: first, 'absolutely' infers a definite and unquestionable formulation; second, CL's 'fantastic' is not suggesting that the GP's approach was good, but that it was in some way remarkable. This proposes that the phenomenon is in the object and is therefore an extreme-case formulation. By invoking such an utterance, CL is emphasising the contrast between the 'particularly bad GP' (Line 7) and the 'old GP' (Line 8), who is 'absolutely fantastic' (Lines 8-9). This functions to make her claim heard as justified and persuasive, and to propose that her 'old GP's' practice is right and preferential (Pomerantz 1986).

The deployment of 'just' (Line 7) on this occasion functions in the 'emphatic meaning' to emphasise the expression with which it enters into construction (Lee 1987). Therefore, CL's deployment of 'just' (Line 7) emphasises 'what she apparently 'felt' (Line 7), as a way to build up a negative assessment, beginning with a personal perspective of 'I think' (Line 7).

This is followed by the production of a potentially negative assessment and subsequent criticism in relation to the GP: 'that was a particularly bad GP to be honest' (Line 7). Edwards and Fasulo (2005) examined 'to be honest' phrases in three environments; in dispreferred answers to questions; in assessments; in answers to questions (Q-A sequences) in police interrogations. On this occasion, CL's use of 'to be honest' functions as an attended-to relevance to assessing the character of the GP. CL thus justifies her actions by providing some initial accountability for the potentially contentious talk about the GP (Edwards and Fasulo 2006).

CL follows this with a disclaimer, '...but I think when I went to see a homeopath that is what I felt I felt you are actually listening to me and you're actually wanting to help' (Lines 9-11), as a potential assessment designed to promote and

boost homeopathic practice. More than this, it outlines two potentially positive attributes, namely that the homeopath actually listened and wanted to help. The disclaimer is positioned at this part of CL's account as a way of disclaiming or offsetting any possible challenge that she visited a homeopath because of having an axe to grind with all former GPs. It is also her way of attending to and managing her own personal accountability in terms of the potentially contentious issue of inferring that the GP is viewed as to blame by CL. Moreover, the disclaimer offers a form of variation which can be observed in CL's account as she works up potentially positive attributes vis-à-vis the homeopath, such as 'actually listening' (Line 10) and 'actually wanting to help' (Lines 10-11) (Hewitt and Stokes 1975). Again, the objective and factual properties of the event are talked up with the deployment of CL's active voice, which attends to encouragement: 'I felt you are actually listening to me and you're actually wanting to help' (Lines 10-11). The inference is that this segment of talk was heard like that on a prior occasion (Wooffitt, 1992). Furthermore, the organisation of her talk here emphasises the potential benefits of the homeopath who actually listens and wants to help, in contrast to the criticisms concerning the GP (Wooffitt 1992).

Although CL's account infers that the homeopath has certain benefits with regards to 'listening' (Line 10) and 'wanting to help' (Line 11), she justifies orienting to the homeopath due to the apparent criticisms, failures and potential disappointments in relation to the GP's practice.

7.2.1 Formulating the (Mundane) 'X' then (Extraordinary) 'Y' Device

In the following three Extracts, 7:5-7:8, the interviewees' accounts are centred primarily on what is commonly formulated as an unexceptional version of an

extraordinary event. In a formulation like this, the speaker will often adopt the ‘At first I thought ...’ (mundane X) ‘but then I realised...’ (extraordinary Y) device (Jefferson 1984; Wooffitt 1992). It is the way that the speakers handle contentious and potentially controversial knowledge claims and topics (homeopathic practices) by deflecting attributional inferences about their own potentially biased description to promote the externality of the event. In doing so, the speakers work to imply that the contingency of the event resides in another or can be found in circumstances out with human agency. Drawing upon this discursive construction indicates to the listener that the events and circumstances are possibly highly contentious and controversial.

The interactional business functions to build up the credibility of the interviewees’ practices and at the same time is a way to deal with criticisms and justify looking to homeopathic practice. This format and way of accounting is seen below:

Extract 7:5

1. CC: so how do you know about homeopathy
2. AM: how do I know about it well I can I can’t really remember (.) the first
3. time I can’t really ((inaudible)) about it
4. CC: okay =
5. AM: = when I was in my early twenties I worked for a whole-food shop in a
6. whole- food co-op shop in Glasgow called ((name)) =
7. CC: = oh yes =
8. AM: = and the first homeopath I ever saw I knew through there and actually
9. it was a student and he was looking for cases to take
10. CC: yes
11. AM: people to take to practice on so it was quite a lot cheaper and at that
12. time I had a health problem that I had ehh (.) mm (.) really bad
13. sinusitis I had antibiotics but it hadn’t been dealt with and it wasn’t
14. good and he was around and he was there (.) so that’s how I came to
15. get that first healing

In Extract 7:4, the first analytical point to note is that AM (the interviewee) discusses a prior experience where he displays a defensive orientation of his practice,

which attributed to the first time he used a homeopath. The function of AM's strategy is to enhance the credibility of his practice. It subsequently transpires that he attributes the first-time event to the availability of the student (homeopath) and a really bad sinusitis that antibiotics were unable to heal. The inferential work being managed concerns the boosting of homeopathic practice and at the same time works to criticise medicine for its potential limitations. AM's potential 'troubles telling' sequence is structured in a (mundane) 'X' then (extraordinary) 'Y' form as a way of constructing objectivity and persuasiveness into the claims being made (Jefferson 1984; Wooffitt 1992). In so doing, AM talks up homeopathy as a 'last-resort-form' and 'type' of practice, which is structured and contrasted in a homeopathy/mainstream medical dyad.

CC's (the researcher's) question 'so how do you know about homeopathy' (Line 1) is designed to elicit a response from AM containing an explicit reference to homeopathy, inferring that a response will have an orientation with resources related to this topic. Accordingly, AM treats CC's utterance as a request and responds with 'how do I know about it well I can I can't remember (.) the first time I can't really ((inaudible)) about it' (Lines 2-3), which displays a rhetorical question that is answered by AM himself. Moreover, this is observed to be a problematic construction in the way that his hedging and claiming not to remember is a practical activity and relevant to the interaction. By producing this claim, AM implies that 'X' was previously known. As a discursive activity AM's apparent not remembering can be observed as a potential evasive device and as a way of attending to his responsibility to account for the truth and accuracy of the event.

Furthermore, AM's initial construction is designed to substantiate the explicit claim that his lack of knowledge of the proposed topic from CC is attributed to a

cognitive issue in the form of a poor memory. In so doing, AM implicitly portrays objectivity to the not-remembering activity and attributes it to the cognitive process over which there cannot be any control, and thereby diminishes individual agency (Wooffitt 1992). It is also a way for AM to manage and attend to responsibility in relation to his personal accountability, making it difficult for any potential challenges to authenticity regarding the claims being made.

Following this, AM invokes as relevant to the interaction, ‘when I was in my early twenties I worked for a whole-food shop in a whole-food co-op shop in Glasgow called ((name)) and the first homeopath I ever saw I knew through there and actually it was a student and he was looking for cases to take people to take to practice on’ (Lines 5-11), which can be heard as a way of justifying his practice. The notion of looking to homeopathy is attributed to the homeopath who was looking for cases—not AM actively seeking homeopathic treatment. By doing this, AM’s inferences can make it difficult to challenge on the grounds that he is seen to promote homeopathy or has a vested interest in doing so. AM is thus reporting an activity, ‘I worked for...’ (Line 5), which is a feature of the mundane ‘X’ component of the ‘X then Y’ device, whereby he is observed to be emphasising the ordinariness and contingency of the event being described (Wooffitt, 1992). More than this, AM is observed to recount and convey an accurate and genuine personal experience and attend to the detail of managing further issues in relation to accountability in the telling (Edwards 1997; Edwards and Potter 1992).

A further analytical point concerning AM’s construction is that it is designed in what Wooffitt (1992) identified as a two-part organisation in order to develop the setting in a three-part sequence—generally at the beginning of a description related to experiences. The first setting is in terms of age: ‘I was in my early twenties’ (Line 5).

The second component provides a formulation of the place: ‘I worked for a whole-food shop in a whole-food co-op shop in Glasgow called ((name))’ (Lines 5-6). During the third part of the sequence, AM goes on to describe how the first homeopath there was a student; looking to practice on people, which highlights that homeopathy was not something that he actively sought or requested. Rather, there are elements attributed to the notion of chance or certainly events as part of ‘out-there-ness’ (Potter 1996): ‘a student and he was looking for cases to take there was a student looking to practice on people’ (Lines 9-11). By invoking the inferential work in this format, AM provides accurate objective evidence to substantiate his claims and at the same time introduces the sequence of events to portray a vivid description as part of authenticity and fact-construction activities (Edwards and Potter 1992; Wooffitt 1992).

AM elaborates further with ‘so it was quite a lot cheaper and at that time I had a health problem that I had ehh (.) mm (.) really bad sinusitis I had antibiotics but it hadn’t been dealt with and it wasn’t good and he was around and he was there (.) so that’s how I came to get that first healing’ (Lines 11-15). In a defensive orientation of his practice, AM formulates as credible a potential criticism directed at the apparent failure of mainstream medical practitioners as a justification of his practice to look to homeopathy.

More than this, AM attributes a potentially amenable price, ‘it was quite a lot cheaper’ (Line 11), a possibly severe health condition, ‘really bad sinusitis’ (Line 11), a potential criticism in relation to failed treatment, ‘I had antibiotics but it hadn’t been dealt with and it wasn’t good’ (Lines 13-14), and the apparent convenience and contingency of looking to homeopathy, ‘and he was around and he was there’ (Line 14), as relevant factors in relation to treatment benefits.

By claiming ‘so that’s how I came to get that first healing’ (Lines 14-15), AM invokes the (extraordinary) ‘Y’ component of the ‘X then Y’ device by portraying the event as something truly remarkable, happening in the form of a successful treatment (Wooffitt 1992). By producing a response in this way, AM can be heard to be working up his account by externalising it as something that a neutral, competent observer could experience in a similar position, which implies an authentic persuasive value to the potentially contentious claims being made. Moreover, AM’s ‘first healing’ (Line 15) is displayed and presented as a potentially exceptional outcome to the prior events described.

AM presents homeopathy as a treatment with potential benefits. However, the potential downside is to orient to it as a ‘last-resort-form’ and ‘type’ of practice. In doing so, AM is heard to enhance his individual practice as credible. At the same time, he is critical of an apparent failed treatment of ‘antibiotics, (Line 13), which is the fundamental basis for looking to homeopathic treatment.

Extract 7:6

1. CC: em (.) why did you choose to use homeopathy
2. Z: years ago (.) eh eighty four (.) I had shingles and I came down to see
- 3 doctor ((name)) and at that time he says there was nothing they could
- 4 do for it (.) it would spread over (.) however he said we’ll try
- 5 homeopathic Rhus Tox I think it was (.) and I took it and the shingles
- 6 just stopped dead (.) coincidence I don’t know

The first analytical point in Extract 7:6 with Z (the interviewee) is that he works up a vivid description inferring that it is a factual, authentic and credible representation of a prior experience (Edwards and Potter 1992). On this occasion, Z’s justification to being introduced to homeopathy is attributed to the apparent failure of mainstream medical practices. Z goes on to promote homeopathy with a miraculous outcome in the treatment of ‘shingles’ (Line 5) as the interactional business

accomplished. The effect is to deflect attributional inferences about his possible bias and, at the same time, promote the objectivity of the event. Z constructs the intrinsic effects of homeopathy by invoking an apparently biographical account constituting the notion of homeopathy as a form of treatment with miraculous effects.

In so doing, Z can be observed to enhance the credibility of his individual practice and talk up the potential medicinal properties and benefits of homeopathy. Z constructs his response by deploying the (mundane) 'X' then (extraordinary) 'Y' device to maximise the persuasive value of his account and the social actions being performed. On the downside, homeopathic practice is portrayed as a 'last-resort-form' and 'type' of practice. I shall now discuss the various discursive devices Z deploys to build up his account to appear as a factual set of events (Edwards and Potter 1992).

CC's utterance, 'why did you choose to use homeopathy' (Line 1), is designed and framed as a request to elicit a response from Z concerning his decision to use homeopathy. Z responds immediately with explicit attributions that can be observed to account for his apparent reasons for looking to homeopathy. In a defensive orientation of his practice, Z produces a three-part formulated response: the setting, 'years ago (.) ehh eighty four' (Line 2); the problem, 'I had shingles' (Line 2); the action, 'I came down to see doctor ((name))' (Lines 2-3). Each item on the list offers a range of inferences to suggest that Z is reporting a factual event, which infers a routine (mundane X) visit to the 'doctor' (Line 3). By working up a precise description of setting, problem and action, Z presents this particular episode as a vivid recollection of a previously experienced event, and this adds facticity and credibility to the account and is how Z attends to personal accountability (Edwards and Potter 1992; Wooffitt 1992).

Next, Z incorporates and utilises the discursive device of an active voice when referring to the doctor, claiming ‘at that time he says there was nothing they could do for it (.) it would spread over’ (Lines 3-4) as a way of criticising the treatment option available and making the claim credible and attributing the lack of options available to mainstream medical practices. Z follows this with a further active voice of the doctor who promotes ‘however he said we’ll try homeopathic Rhus Tox’ (Line 4). Z produces these utterances as if they were heard like that on a prior occasion. To reiterate, the use of an active voicing is a common feature of fact construction, suggesting that other people, if present, might have observed the same utterance, and thereby reinforces the objectivity of the inference (Wooffitt 1992). Employing a formulation of another person’s actual talk corroborates the accuracy of Z’s description and substantiates reliability and authenticity (Wooffitt 1992). However, by stating ‘I think it was’ (Line 5), Z is offering a ‘lay’ version of events based on an assessment of the prior event; his labelling of the homeopathic remedy Rhus Tox suggests that it is in some way not familiar to him.

Z produces a further promotion of homeopathy by claiming ‘and I took it and the shingles just stopped dead (.) coincidence I don’t know’ (Lines 5-6), Z can be observed as deploying the (extraordinary) ‘Y’ device in juxtaposition to the (mundane) ‘X’ formulation to emphasise the contingency of the event. Z’s ‘Y’ component reports his first awareness of the phenomenon—‘the shingles stopped dead’ (Line 5)—which is further furnished with the use of ‘coincidence’ to infer a dramatic (extraordinary) event had occurred. The use of the particle ‘just’ (Line 6) on this occasion has the ‘emphatic’ meaning, which functions to emphasise the suddenness, ordinariness and yet dramatic ‘stopped dead’ (Line 6) effect that homeopathy apparently had on the shingles (Lee 1987). Z’s use of ‘I don’t know’

(Line 6), which is situated following a promotion regarding a ‘coincidence’, displays and indicates how Z is attending to the responsibility of his own personal accountability in the way he manages his stake and interest. Z displays potential disinterestedness precisely at a point in the account where there could be a particular issue concerning credibility and authenticity. Therefore, Z’s ‘I don’t know’ (Line 6) is how he manages to inoculate against stake and interest. In doing so, Z’s deployment of ‘I don’t know’ (Line 6) is used to head off a potential counter-challenge and can be heard as an uncertainty marker and is one way he attends to the notion of accountability (Potter 1996; Potter 1997).

In the various ways demonstrated above, Z constructs his talk to enhance the credibility of his practice in looking to homeopathy. By presenting his claims through this strategy, Z orients to homeopathic treatment in relation to a criticism of an apparent failure of medicine.

Extract 7:7

1. CC: so why did you choose to use homeopathy
2. TB: well that’s quite interesting (.) my son was about one and a half and he
3. was (.) he had a really bad temperature and he wasn’t very well at all
4. (.) and I called the doctors in (.) it just so happened it was doctor
5. ((name)) that came in (.) em I had given him Calpol (.) but we didn’t
6. ken at the time that Calpol was making him (.) it was worse (.) it’s the
7. sugar and the colouring in it makes him get diarrhoea so I had given
8. him that to reduce the temperature and it wasn’t working (.) doctor
9. ((name)) came in and he put five (.) which I didn’t ken at the time it
10. was homeopathic tablets (.) but he gave me five tablets and he said if
11. you give him one (.) like he gave him one and he says I want you to
12. give him one every five minutes for the next twenty five minutes and
13. then see how he is (.) and I done what he says being a bet (.) well we’ll
14. see what these are ehh (CC: yes) and within an hour he was pretty
15. much back to normal and I thought this is like magic

The complexity of the experience that TB (the interviewee) talks up in Extract 7:7 is constructed in a descriptive biographic/narrative format involving a child who

received homeopathic tablets from the doctor. Apparently, after taking homeopathic treatment in a potentially critical situation TB's son was 'pretty much back to normal' (Lines 14-15). In so doing, TB describes an everyday event with an extraordinary outcome. TB, by deploying the (mundane) 'X' then (extraordinary) 'Y' device, presents herself as observing an event and having the kind of experience that any neutral, competent observer would have in a similar situation (Wooffitt 1992). What we see again is that in this strategy TB works to enhance her personal credibility in looking to homeopathic treatment and at the same time bolsters the exceptional properties of homeopathic treatment. Although TB is observed to attribute positive characteristics to homeopathy, a potential downside is to present homeopathy as a 'last-resort-form' and 'type' of practice oriented to after a criticism and failure of mainstream medicine. I will now discuss the various discursive devices that TB invokes and mobilises through her talk to make her account and the actions being performed persuasive and factual.

In a direct response to CC's utterance, 'so why did you choose to use homeopathy' (Line 1), TB immediately makes the discursive resources available to set the scene of the narrative by deploying (mundane) 'X' of the 'X' then (extraordinary) 'Y' device (Lines 2-10) to talk up the ordinariness of the event. TB begins with 'well that's quite interesting (.) my son was about one and a half and he was (.) he had a really bad temperature and he wasn't very well at all' (Lines 2-3) as relevant to the interaction. This response is constructed in a three-partedness format, which indicates a general commonality to the items on the list.

TB's first item, 'my son was about one and a half' (Line 2), is a reference to TB's son as the recipient of the potential problem. At the same time, by invoking 'my son' (Line 2) TB corroborates her evidence with the use of 'the other'. Second, TB

makes an explicit medical complaint, 'he had a really bad temperature' (Line 3), which emphasises the extremeness of a potential physiological problem proposed by invoking 'bad temperature' (Line 3), and which proposes that the phenomenon is in the object. Here, TB's 'really bad temperature' (Line 3) is used to legitimise and justify the third part of her three-part list structure as an attribute by proposing that he 'he wasn't very well at all' (Line 3). This is therefore heard as an extreme-case formulation. By formulating it as 'really bad' (Line 3) in this context, TB describes the proportion as excessive and attributes the cause as being in the object 'he' (Line 3) (Pomerantz 1986).

In the segment of talk that follows this, TB constructs and describes vividly a potentially negative event relating to the adverse effects of 'Calpol' (Line 5) (medical treatment) on her son. She claims, 'and I called the doctors in (.) it just so happened it was doctor ((name)) that came in (.) em I had given him Calpol but we didn't ken at the time that Calpol was making him (.) it was worse (.) it's the sugar and the colouring in it makes him get diarrhoea so I had given him that to reduce the temperature and it wasn't working' (Lines 4-7). This presents as a potential criticism of medical practices through treatment utilising 'Calpol' (Line 5). More than this, TB makes explicit that 'Calpol' (Line 5) is apparently attributed to the failure and contributed to an exacerbation of his symptoms.

By making the potential criticism relevant, 'I called the doctors in' (Line 4) and 'we didn't ken at the time that Calpol was making him worse' (Lines 5-6), TB builds up consensus and corroborative evidence into the claims regarding the decline of her son's condition. In reporting an event in this way, TB is seen to be merely passing on neutral information whilst minimising her involvement in a previously experienced event, and thereby diminishes personal agency regarding the claims being

made. Portraying talk in this way can be used to refer to any past event that is not contingent upon human agency, thus TB maximises the inferences made as authentic whilst attending to her own personal accountability (Edwards and Potter 1992; Wooffitt 1992).

In the use of the phrase ‘just so happened’ (Line 4) on this occasion, ‘just’ has a ‘specificatory meaning’, which functions to minimise the significance of the event of the visit of ‘doctor ((name))’ (Lines 4-5). Hence, ‘just’ (Line 5) on this occasion identifies a marginal phase, ‘doctor ((name)) came in’ (Lines 4-5), which is situated within a timeframe (Lee 1987). In so doing, TB contrasts the possibility of the visit by a different doctor, implying that there is no bias in the inference made to ‘doctor ((name))’ (Lines 4-5). TB’s potential criticism, ‘I had given him Calpol but we didn’t ken at the time that Calpol was making him (.) it was worse...’ (Lines 5-6), is heard as a disclaimer used to ward off any possibly negative attributions in relation to TB and the apparent administering of ‘Calpol’ (Line 5).

Thus the disclaimer, which is corroborated with ‘we’ (Line 5), attends to the business of heading off a potentially negative challenge to TB’s personal accountability—the possible inference that TB is viewed as someone who wishes to promote homeopathy or has a vested interest in it (Hewitt and Stokes 1975). Next TB’s critical, ‘it’s the sugar and the colouring in it makes him get diarrhoea so I had given him that to reduce the temperature and it wasn’t working’ (Lines 6-7), attributes her son’s apparent deterioration and subsequent diarrhoea to ‘sugar’ (Line 7) and ‘colouring’ (Line 7) as an apparently acceptable course of action. This can be heard to emphasise and externalise the event, suggesting that it could happen to anyone in that way and therefore making the experience and the claims credible (Wooffitt 1992).

TB works up a contingent element to the account by claiming, ‘doctor ((name)) came in and he put five (.) which I didn’t ken at the time it was homeopathic tablets’ (Lines 8-10) as a good example of the (mundane) ‘X’ component of the ‘X’ then (extraordinary) ‘Y’ device. This indicates the contingency of the event through her construction of a routine visit from the doctor. TB builds further credibility into the inferences by making explicit her potential uncertainty marker regarding homeopathic tablets when she states, ‘he put five (.) which I didn’t ken at the time it was homeopathic tablets’ (Lines 9-10), which can be observed as drawing upon ‘stake and interest’ as relevant to a participant’s concern. Therefore, TB inoculates against the possibility of the description being challenged due to ‘stake and interest’ and in this way manages her personal accountability. TB offers what is heard as potential denial regarding her prior knowledge of homeopathy, ‘I didn’t ken at the time it was homeopathic tablets’ (Lines 9-10), which works to further attend to and manage her personal accountability by inferring that she had no prior knowledge of homeopathy and therefore no interest in promoting it (Potter 1996). Further, like all oral narratives, this one requires an evaluative framework. Here the good character, ‘doctor ((name)) came in’ (Line 8), is invoked to produce the potentially positive outcomes with which to contrast the exceptional outcome. In doing so, TB externalises her account to the contingency of events that any neutral competent observer would experience in a similar situation, which adds credibility and objectivity to the overall claims being made (Wooffitt 1992).

To illustrate her claims, TB constructs with the use of vivid description: ‘but he gave me five tablets and he said if you give him one (.) like he gave him one and he says I want you to give him one every five minutes for the next twenty five minutes and then see how he is’ (Lines 10-13). This is a way of potentially defending

her practice, and is portrayed as explicit behaviours, medicinal directions and indications apparently received during a prior activity with the doctor. On this occasion, TB introduces the listener, CC, to the active voice. TB uses the voice of the doctor in a reported dialogue sequence concerning instructions of a precise medication regime: ‘if you give him one’ (Lines 10-11) and ‘I want you to give him one every five minutes for the next twenty minutes and then see how he is’ (Lines 11-13) are designed to be heard as the way it was spoken on a prior occasion and thus presents the account as an accurate portrayal of events (Wooffitt 1992).

Next, TB furnishes her account with what is constructed as a reference to her behaviour, which unfolds chronologically from the previous inference: ‘and I done what he says being a bet (.) well we’ll see what these are ehh’ (Lines 13-14). Again TB adopts an active voice—‘well we’ll see what these are ehh’ (Lines 13-14)—by characterising her own utterance to establish some features of the interaction with the doctor. TB works up the account in order to portray it as talk that was heard like that at the time, thereby adding authenticity to the inquisitive claims being made (Wooffitt 1992). Moreover, in presenting in this way, TB is heard to be managing issues in relation to personal accountability. That is, the stake inoculation of ‘we’ll see what these are’ (Lines 13-14) presents TB to be heard as potentially sceptical in relation to the tablets (Potter 1996). In addition, homeopathy is portrayed as something that was offered, without TB knowing, by the doctor. However, by displaying potential scepticism, TB’s talk works to promote homeopathy by what follows immediately in her account.

In the final segment of talk, TB is observed to be using the (extraordinary) ‘Y’ component of the ‘X then Y’ device. TB promotes homeopathy by claiming ‘within an hour he was pretty much back to normal and I thought this is like magic’ (Lines

14-15). The juxtaposition infers that the apparent result was everyday and routine. However, the result was not just positive: rather, the event and subsequent result is described persuasively as ‘within an hour he was pretty much back to normal’ (Lines 14-15) and ‘I thought this is like magic’ (Line 15), partly formulating the miraculous inferences. By an explicit reference to ‘within an hour’ (Line 14), TB works up the time as a relevant resource to add persuasiveness to the ‘magic’ (Line 15) properties, inferring that ‘homeopathic tablets’ offered an apparent exceptional recovery.

Therefore, by drawing on various discursive devices—specifically the ‘X’ then ‘Y’ device identified above—TB works to enhance personal credibility for looking to homeopathy. At the same time, TB presents her strategy as an accurate, factual series of events. However, TB was observed to look to homeopathy after criticising the failure of medicine, which works to portray homeopathy as a ‘last-resort-form’ and ‘type’ of practice.

Extract 7:8

1. CC: yeah (.) so why did you choose to use homeopathy
2. QV: em (.) initially it wasn't (.) I suppose it wasn't a choice I made (.) it
3. was a choice that was offered to me by my GP (.) em probably about
4. twenty-two years ago when doctor ((name)) first came to the practice
5. (.) em the first time I was offered it it was actually for my daughter
6. who was I think about five at that time and she developed warts on her
7. hands and in a small child it's very difficult to get rid of (.) and very
8. painful to get rid of and we'd gone as far as we could with salicylic
9. acid ((medical treatment)) and it just didn't do the trick and it was too
10. uncomfortable he (.) suggested homeopathy and I was absolutely
11. amazed that by about three weeks later there was no warts whatsoever
12. on her hands incredible

The first point to note in Extract 7:8, the research interview with CC (the researcher) and QV (the interviewee), is that, similarly to TB, the biographical strategy is centred around criticisms in relation to a child with an apparently potentially difficult condition to treat through mainstream medical interventions—

namely, QV's daughter with warts on her hands. In a similar way to TB, QV describes an everyday event that has an apparently exceptional result. TB states 'I was absolutely amazed...' and 'there was no warts on her hands incredible' (Lines 10-12), which is observed as a truly extraordinary result as part of the 'X then Y' device (Jefferson 1984; Wooffitt 1992). Again, in attending to and managing her personal credibility for looking to homeopathy, QV constructs her account to counter being viewed as a person who wishes to promote homeopathy, working to build up her account as a mundane activity to portray herself an 'ordinary person doing ordinary things'. I now discuss the various rhetorical devices used that add factuality and persuasiveness to QV's account.

CC's request, 'yeah (.) why did you choose to use homeopathy' (Line 1), is oriented to by QV with an immediate talking-up of events in the structure of the (mundane) 'X' then (extraordinary 'Y' device. To begin, QV responds to CC with 'em (.) initially it wasn't (.) I suppose it wasn't a choice I made (.) it was a choice that was offered to me by my GP' (Lines 2-3) as a way of portraying looking to homeopathy as contingent on the GP's activity and a way of orienting to the mundane 'X' (Lines 2-10) properties of her account. Moreover, this reports her diminished involvement in choosing homeopathy, which is instead attributed to the GP. In so doing, QV can be observed to be drawing upon stake inoculation to manage the risk or the possibility that her description might be seen as a motivating factor to promote homeopathy. QV's 'I suppose it wasn't a choice I made...' (Line 2) is used to inoculate against a potential challenge that indeed she has an allegiance to, or vested interest or stake in, promoting, homeopathy and is how QV manages factors relating to her own personal accountability (Potter 1996). More than this, QV's claim can be

heard as an outcome of her daughter's failed treatment by the GP, which is revealed further in the account.

In addition, QV's 'it was a choice that was offered to me by my GP (.) probably about twenty-two years ago when doctor ((name)) first came to the practice (.) em the first time I was offered it it was actually for my daughter' (Lines 2-5) is offered as vivid detail in a two-part organisation format to justify the event and in defence of her practice. The first item on the setting/setting sequence portrays an activity attributed to the GP, namely 'it was offered to me by my GP' (Lines 2-3), which is followed with a defined time, 'probably about twenty two years ago' (Lines 3-4), designed to portray and substantiate the event as an accurate and authentic biographical account. The second item, 'when doctor ((name)) first came to the practice' (Line 4), is formulated as a reference to setting, emphasising the ordinariness of the doctor's coming to the practice. The third item, that the recipient of the treatment was her daughter, is offered as corroborative evidence: 'em the first time I was offered it it was actually for my daughter' (Lines 4-5) portrays the event as something that QV has potentially witnessed. In addition, the repetition of 'first' (Lines 4-5) illustrates the emphasis on the first time and thus infers that she has used homeopathy on several occasions.

Further, the inferential business of 'em the first time I was offered it it was actually for my daughter' (Lines 4-5) suggests that QV is characterising a good example of the mundane 'X' of the 'X' then (extraordinary) 'Y' device by building up the ordinariness of the activity as everyday and routine (Wooffitt 1992). At the same time, this device is deployed to work up objectivity and facticity into the claims being made.

QV formulates a potential assessment, ‘who was I think about five at that time’ (Line 6), implying a way of confirming the event. QV immediately follows this with ‘and she developed warts on her hands and in a small child it’s very difficult to get rid of (.) and very painful to get rid of’ (Lines 6-8), which is offered as a construction of the persistent and potential complexity of the medical complaint. In doing so, QV is concerned with describing the age, condition and effect of her daughter’s ailments in explicit factual terms in order to illustrate the problematic nature of her daughter’s predicament (Edwards and Potter 1992). Further, QV’s ‘very difficult to get rid of’ (Line 7) and ‘very painful to get rid of’ (Lines 7-8) offer a detailed characterisation of the potential longevity and severity of the ailment—‘warts on her hands’ (Line 6)—as a physiological explanation. This adds objectivity and corroborative evidence by invoking the ‘other’ who apparently experienced the event (Horton-Salway 2001; Wooffitt 1992).

QV makes explicit in a three-part construction, ‘and we’d gone as far as we could with salicylic acid ((mainstream medical treatment)) and it just didn’t do the trick and it was too uncomfortable’ (Lines 8-10), which works as a criticism in relation to the treatment. However, accounting in this way attributes a potential criticism in relation to ‘salicylic acid’ (Lines 8-9) as an apparent mainstream medical treatment option that was unsuccessful. On this occasion, the function of the particle ‘just’ (Line 9) is to ‘emphasise’ the expression with which it enters, namely that ‘salicylic acid’ (Lines 8-9) did not ‘do the trick’ (Line 9). Therefore, ‘just’ (Line 9) should be regarded as a way of highlighting the potential downside of the treatment (Lee, 1987).

QV makes relevant to the interaction, ‘he (.) suggested homeopathy’ (Line 10), which is explicitly attributed to a contingent decision the doctor made in relation to

her daughter's condition. The inference is made credible, since any doctor might be expected to behave in such a manner and is part of normativity in medical encounters. In addition, the discursive device of the active voice is used as corroborative evidence and gives the impression it was said like that at the time by the GP. Note also that QV is observed to make a footing shift, claiming 'he suggested homeopathy' (Line 10), which further builds neutrality, objectivity and persuasiveness into the claim attributed to what the GP offered. It also illustrates the accuracy and reliability of the events being described (Goffman 1981; Wooffitt 1992). In doing so, QV attends to and manages her personal accountability to counter any potential challenge that she is someone who has a stake in promoting homeopathy.

QV portrays coming to a conclusion in relation to the prior evidence. Providing the claim in a three-part evaluative sequence, QV promotes homeopathy's broad range of effects by claiming 'and I was absolutely amazed that by about three weeks later there was no warts whatsoever on her hands incredible' (Lines 10-12). The first item, 'I was absolutely amazed' (Line 10), portrays the initial exceptional component 'Y' of the 'X then Y' device, which can be heard as an extreme-case formulation. QV is seen in a defensive orientation to be building up her testimony as something out of the ordinary, where she is portrayed in the situation as experiencing a perceptual change due to the exceeding of her expectations. This is thus an extreme-case formulation. As well as indicating the extent of amazement as complete and excessive, QV's 'absolutely amazed' operates to make sense as an appropriate description with which to emphasise the level of surprise (Pomerantz 1986).

The second item, 'by about three weeks later' (Line 11), offers a precise time, which is heard as quick in proportion to the prior difficulties, with 'no warts whatsoever on her hands' (Lines 11-12). Third, stating that 'there was no warts

whatsoever on her hands incredible' (Line 11) adds further miraculous inferences to the curative effects and benefits of homeopathic practice.

By designing her response around the 'X' then 'Y' device, QV is observed to talk about homeopathy as offering potential benefits and looks to it after criticising medicine for a treatment failure.

7.2.2 Patients 'doing being ordinary'

A final feature of Extracts 7:5-7:8 is that in presenting their claims in this way the interviewees are providing empirical evidence in a before/after formulation to justify looking to homeopathic practice. These interviewees are not promoting contentious or controversial information; rather, they are reasonable neutral competent observers, merely passing on the usualness of facts as they are. In other words, they are 'doing being ordinary' as a way of building personal credibility as reliable speakers and work to be heard as 'ordinary people doing ordinary things' (Sacks 1992; Stokoe and Hepburn 2005) on this occasion as patients describing mundane events in looking to homeopathic practice.

7.2.3 Summary of Analysis in Extracts 7:1-7:8

In summary, throughout the above extracts 7:1-7:8 the interviewees defended their practices by orienting to the criticisms-of-medicine-to-justify-homeopathy strategy, where they describe the failures of mainstream medical practices as a credible basis for looking to homeopathy. From the questions posed by CC, the interviewees bring and make relevant their own categories and contrast structures—

i.e., the (mundane) 'X' then (extraordinary) 'Y' device, mobilised for specific social actions to enhance their practice as credible. In doing so, the interviewees are observed to adopt various discursive devices to maximise the persuasive power of their descriptions and social actions (Edwards and Potter 1992). From a 'top-down' perspective, notions of mainstream medicine are taken as the yardstick for practice and deployed as the site for judging all medical practices. The interviewees thus position homeopathic practices in a culture of scepticism as a contested, controversial knowledge claim. Moreover, this suggests that making their individual practices credible presents difficulties for these interviewees. The wider effect of this strategy is to potentially and continually marginalise homeopathy from mainstream acceptance when one considers the broader social context (Wetherell 1998).

However, not all interviewees worked up their credibility in this way. I shall now introduce the second strategy, managing-homeopathy-as-alternative, as another way of accounting for their practice.

7.3 Managing-homeopathy-as-alternative Strategy

In the second strategy, managing-homeopathy-as-alternative, the findings show the ways in which the interviewees introduce personal factors that offer homeopathy as a problematic, troubled, out-of-the-ordinary and alternative 'type' of practice and account for their individual use of it. The interviewees accomplish this through 'lay versions' of their experiences with homeopathy. By these means, homeopathy is presented as a practice on the fringes of mainstream medical practice. Again, the interviewees' strategies function to enhance the credibility of their own

individual practice. In doing so, they attend to and manage issues of personal accountability, thus illustrating the difficulties involved in making homeopathy credible. In performing the social actions that they do, the defence-oriented talk of their practice in relation to homeopathy is presented as a controversial and contested knowledge claim.

7.3.1 Talk about the alternative

This is seen in the following Extracts 7:9-7:12:

Extract 7:9

1. CC: okay (.) so what is homeopathy
2. SP: em (.) homeopathy (.) it's a kind of (.) I suppose it's an alternative
3. medicine but it
4. CC: um
5. SP: em (.) to me it is my medicine (.) it's not an alternative (.) it's the
6. medicine I've chosen =
7. CC: = okay (.) so what do you mean by alternative medicine (.) you
8. mentioned there =
9. SP: = to conventional (.) it's no what I suppose up until a few years ago
10. was considered (.) well in my life the normal medicine (.) em (.)
11. whereas now it is (.) ken like it is just em my first choice what I would
12. go for (.) after a good experience of it with my daughter

In Extract 7:9, SP (the interviewee), through a defensive orientation, is heard to be defending a factual and solid account as she describes homeopathy in a contrasting frame to notions of mainstream medicine. In doing so, homeopathy is presented as a difficult-to-define, problematic alternative 'type' of practice. Note that SP elaborates her claim by orienting to the notion that alternative medicine and homeopathy was not the 'normal medicine'. However, as her account unfolds, SP portrays homeopathy as a 'normal medicine' and consequently it is presented as her apparent first choice. In accounting this way, SP can be seen to construct homeopathic

practice as a potentially controversial, contested and alternative type of practice. At the same time, SP accounts for her use of it in relation to an experience with her daughter. Therefore, the function of SP's strategy is to enhance the credibility of her practice. I shall now illustrate the discursive devices that SP deploys to add persuasiveness to her description.

In a response to CC's request, 'so what is homeopathy' (Line 1), TB, in alignment with CC's reference to homeopathy, offers, 'em (.) homeopathy (.) it's a kind of (.) I suppose it's an alternative medicine' (Lines 2-3). This can be heard as re-assessing a selection of the relevant features: 'homeopathy it's kind of' (Line 2) and 'I suppose it's a kind of alternative medicine' (Lines 2-3). The re-assessing may suggest that homeopathy is a potentially problematic categorisation for TB. This is followed with 'but it em to me it's my medicine (.) it's not alternative it's the medicine I've chosen' (Lines 3 and 5) as a direct rebuttal of the initial claim. In so doing, SP re-characterises homeopathy as in alignment with medicine and rejects the category of 'alternative'. Further, in the first part of the claim there is an explicit reference to homeopathy—'homeopathy (.) it's a kind of (.) I suppose it's an alternative medicine' (Lines 2-3)—that portrays it as analogous to the category of alternative medicine and in some way out of the ordinary. TB follows this with a disclaimer—'but it em to me it's my medicine (.) it's not alternative it's the medicine I've chosen' (Lines 3 and 5)—as a way of promoting her apparent use of homeopathy. This is designed to head off any potential challenge that SP might be heard to be prejudiced or to be inferring negative attributions by suggesting that homeopathy is in alignment with an alternative medicine, and is a way of countering any potential challenges to the notion of responsibility or personal accountability on the basis of being viewed as discreditable (Hewitt and Stokes 1975). However, accounting in this way does

suggest that homeopathy is in some way a contested, problematic and potentially controversial medical practice.

CC then produces ‘okay (.) so what do you mean by alternative medicine (.) you mentioned there’ (Lines 7-8) as a request to SP to elaborate on the notion of alternative medicine. SP responds with a defensive orientation, formulating ‘to conventional (.) it’s no what I suppose up until a few years ago was considered (.) well in my life the normal medicine’ (Lines 9-10). This infers that alternative medicine is possibly contested, controversial and not widely accepted as a ‘normal medicine’ (Line 10) and that ‘conventional’ (Line 9) is the term used to legitimise, justify and evaluate her practice. TB then invokes the claim ‘(.) em (.) whereas now it is (.) ken like it is just em my first choice what I would go for’ (Lines 11-12), which serves to demonstrate approval of homeopathy. More than this, it is an explicit orientation to commit herself to the truth of the proposition. The use of the particle ‘just’ (Line 11) on this occasion is ‘depreciatory’, which functions to express an attitude. Therefore, the effect of ‘just’ here is to contribute to the propositional claim of the utterance, ‘my first choice what I would go for’ (Lines 11-12), which adds persuasiveness and signals the unremarkable nature of the claims being made (Lee 1987).

By attributing the experience to her daughter, ‘after a good experience with my daughter’ (Line 12), SP draws on the collaboration of the ‘daughter’ (Line 12) to justify her action and add persuasiveness and factuality to the claim being made (Horton-Salway 2001; Wooffitt 1992).

By accounting in this way and drawing on various discursive devices, SP is observed to be dealing with the issue of personal credibility by building up the facticity of the account to counter any potential challenge that she is someone who has

a stake in promoting homeopathy. Homeopathic practice is talked up as an out-of-the-ordinary, contested and controversial practice and presented explicitly as an alternative when contrasted to notions of mainstream medicine. This illustrates the difficulties SP has in making her homeopathic practice credible. However, SP does offer convincing personal factors in relation to her daughter as a way of justifying her looking to homeopathic practice.

Extract 7:10

1. CC: that's good (.) so what is homeopathy
2. Z: homeopathy (.) eh an alternative medicine (.) frowned on by most of
3. the medical fraternity (.) a lot of them disagree (.) eh (.) I just
4. couldn't tell you (.) I've never really looked it up
5. CC: no =
6. Z: = it's just a way of treating the symptom by a different method (.)
7. I'm looking for another way from the side effects of the alternately
8. regular medicines

The first analytical point of interest in Extract 7:10 is the way that Z (the interviewee), through a defensive orientation, provides information that presents homeopathy explicitly as a controversial and contested alternative medicine. The primary organisational feature of this sequence is that Z initially offers a potentially negative portrayal of homeopathy by invoking a possible criticism—apparently from the ‘medical fraternity’. However, he goes on to invoke personal factors to justify looking to homeopathy as a way of avoiding the ‘side effects’ (Line 7) of the ‘alternately regular medicines’ (Lines 7-8) by contrasting the inferences—‘a way of treating the symptom by a different method’ (Line 6)—in a medicine/homeopathy contrasting frame. The function of Z’s strategy is to bolster the credibility of his homeopathic practices by offering a personal account of his use of it.

CC’s utterance, ‘that’s good (.) so what is homeopathy’ (Line 1), is designed to elicit a response from Z in relation to a description of ‘homeopathy’. Accordingly,

the initial response from Z is to deploy an immediate orientation to medicine, claiming ‘homeopathy (.) eh an alternative medicine’ (Line 2) as a description that portrays the relevant features and characteristics in relation to homeopathy. By invoking ‘alternative medicine’ (Line 2), Z implies that there is a possibly a non-alternative form of medicine to which homeopathy is being contrasted. In this instance, mainstream medical practices are the bottom line against which to measure practice.

Next, Z produces what is heard as a form of prevailing scepticism towards homeopathy and at the same time confirming aspects of disapproval by offering ‘frowned on by most of the medical fraternity (.) a lot of them disagree’ (Lines 2-3). The inferences are worked up as reliable corroborative evidence in relation to ‘the medical fraternity’ (Line 3), and emphasised further with ‘a lot of them disagree’ (Line 3). The inferences carry weight by being attributed to the ‘medical fraternity’ (Line 3), which portrays objectivity and lends factuality to the formulation, adding greater persuasiveness to the claims being made (Potter 1996; Wooffitt 1992). Z’s specific ‘a lot of them disagree’ (Line 3) is designed to defend his claim in relation to the ‘medical fraternity’ (Line 3) as a description illustrating a significant amount of ‘them’ (Line 3) as proportionate to the amount of disagreement. In so doing, Z draws on an extreme-case formulation to provide a sense that the notion of ‘disagree’ (Line 3) is legitimised by ‘a lot’ (Line 3), which is observed as the normal and appropriate behaviour of the ‘medical fraternity’ (Line 3) by virtue of its frequency of occurrence (Pomerantz 1986). Z thus positions homeopathic practice in a culture of scepticism as a controversial and contested knowledge claim.

Immediately succeeding these claims, Z offers an opposing view: ‘eh (.) I just couldn’t tell you (.) I’ve never really looked it up’ (Lines 3-4). On this occasion, the

particle ‘just’ (Line 3) functions to express an attitude in a ‘depreciatory’ context. Here, Z minimises the significance of a particular process by contrasting the two inferences: firstly by denying the referent—‘I just couldn’t tell you’ (Line 3)—and followed secondly through upholding the focal process by attributing a justification—‘I never really looked it up’ (Line 4) (Lee 1987). CC offers ‘no’ (Line 5) as a minimal continuer that works as an agreement token. Z is also working to counter any potential challenges to the legitimisation of previous claims, by suggesting that talking about homeopathy is in some way problematic for him. By attending to his own personal accountability, Z works up the account of homeopathic practice to be heard as information that he is reporting and not solely down to his own opinion.

The second use of ‘just’ in the utterance ‘it’s just a way of treating the symptom by a different method’ (Line 6) permits Z to display the reliability of the initial description of homeopathy as an alternative. Here, ‘just’ works in the ‘restrictive’ sense and functions to propose a meaning which at the same time illustrates the un-remarkableness of the inferences made regarding ‘treating the symptom by a different method’ (Line 6) (Lee 1987). This is followed by Z making explicit personal factors involved in looking to homeopathy—‘I’m looking for another way from the side effects of the alternately regular medicines’ (Lines 7-8)—in the form of a criticism of ‘regular medicine’ (Line 8). This is how Z proportions potential negative inferences to notions of mainstream medical practices, which is apparently motivated by the apparent ‘side effects’ (Line 7). Z thus designs and organises his talk to emphasise the objectivity and facticity of the apparent experience (Wooffitt 1992).

By accounting in this way, Z makes relevant the notion that homeopathy is in some way problematic, contested and controversial when contrasted with mainstream

medical practices. The attributional and referential work does, however, warrant, acknowledge and establish homeopathy as an ‘alternative’ type of practice.

Extract 7:11

1. CC: yeah so what is homeopathy
2. CL: ((laugh)) oh that’s a hard one oh dear (.) I don’t know you’re supposed
3. to do a three year degree to figure that out are you not ehh (.) hmm
4. what is homeopathy (.) well for me certainly homeopathy was just (.)
5. all these alternative natural words come into your mind don’t they for
6. me it was an alternative way for dealing with my problems without
7. resorting to (.) what I would say was traditional medicine

In Extract 7:11, CL’s (the interviewee) account is constructed to be heard as an authentic, factual portrayal of events and, as a strategy, functions to enhance the credibility of her practice. Initially, CL talks down her knowledge in relation to homeopathy by claiming that to have knowledge of the topic one must have the relevant university education. However, CL provides explicit evidence to portray homeopathy in a contrast structure of categories as an alternative to traditional medicine. In doing so, CL introduces personal factors such as ‘it was an alternative way of dealing with my problems’ (Line 6), as a basis and justification for looking to homeopathy. I shall now describe how CL accomplishes this by invoking various rhetorical devices designed to maximise the persuasive power of the descriptions.

First, CC (the researcher) invokes what is heard as a request to CL, ‘yeah so what is homeopathy’ (Line 1). Accordingly, CL responds immediately with ‘((laugh)) oh that’s a hard one oh dear I don’t know you’re supposed to do a three year degree to figure that out are you not ehh (.) hmm what is homeopathy (.)’ (Lines 2-4), thereby explicitly referring to CC’s request. However, this immediate response from CL suggests that talking about homeopathy is problematic and contestable for her. By repeating lexical elements of CC’s request, ‘what is homeopathy’ (Line 4), CL can be

heard to ask a potentially rhetorical question. By accounting in this way, CL is observed to be hedging her response by not offering an immediate and precise definition in alignment with the request from CC.

In doing so, CL infers that the request from CC is a technically oriented question and knowledge claim to which she apparently cannot respond accordingly with a precise definition. In addition, CL's possibly evasive '((laugh)) oh dear that's a hard one oh I don't know' (Line 2) suggests that she is managing 'stake inoculation' and attends to her own responsibility for her personal accountability in what she might say next. This is accomplished in the way that 'I don't know' (Line 2), operates in the interaction and is personal to this situation, in contrast to assuming that CL has no knowledge of the topic of homeopathy. Here, the vagueness of 'I don't know' (Line 2) works against the implication that CL is someone who has a vested interest in promoting homeopathy, and is a way of managing accountability and attending to a sensitive matter generated by CC (Edwards and Potter 1992; Potter 1996). However, CL immediately follows this with a reference to education as a resource—'you're supposed to do a three year degree to figure that out are you not' (Lines 2-3)—and inferring that 'a three year degree' (Line 2) would provide the appropriate information on the topic of homeopathy. CL thus infers that knowledge of and any knowledge claim regarding homeopathy is something accumulated through experience of a formal university-based education in relation to 'a three year degree' (Line 3) (Potter 1996).

In contrast to the initial claims of having no knowledge of homeopathy, CL spontaneously and immediately constructs 'well for me certainly homeopathy was just all these alternative natural words come into your mind don't they' (Lines 4-5) as a defence of her practice. This can be heard as a personal and explicit 'lay' view on the

topic of homeopathy. Here, the particle ‘just’ (Line 4) is used to reinforce the general argument in order to portray the idea of limitation identified by Lee (1987) as the ‘restrictive meaning’. Here, it functions to build credibility into the claim that when the notion of homeopathy is oriented towards, then natural words come prominently into consideration. By invoking ‘all these alternative natural words come into your mind don’t they’ (Line 5), CL offers evidence to provide an explicit description of homeopathy as something natural and alternative. Again, by invoking ‘don’t they’ (Line 5), CL is using this to portray her claim that there is a prior knowledge that is widely and commonly accepted. This is a way that CL attends to the issue of diminishing personal agency, making it hard to challenge her on issues of personal accountability. At the same time, she is working up a consensus with CC.

CL follows this with what is heard as a justification of personal factors in reference to her apparent behaviour in looking to homeopathy: ‘for me it was an alternative way for dealing with my problems without resorting to (.) what I would say was traditional medicine’ (Lines 5-7). By contrasting an alternative way with traditional medicine, CL is explicit in the way that the notion of homeopathy is looked to as an out-of-the-ordinary alternative when compared to mainstream medical practices.

Extract 7:12

1. CC: you mentioned the word marginalisation there (.) what do you mean by
2. that
3. TC: well it’s to do with how society in general views homeopaths (.) it’s
4. still seen as maybe a couple of steps up from witch doctor (.) type
5. thing and there is a kind of grouping together with alternatives (.)
6. alternative religions alternative thinking (.) and I think that does
7. kind of marginalise (.) certainly my own GP considers an
8. osteopath to be just about up there with the witch doctors (.) which
9. is crazy because osteopaths obviously go through their five years or
10. whatever of medical training (.) the most recent homeopath I’ve used
11. was an osteopath I chose her for two reasons one she was available

12. when I had a huge back problem and two because she was
13. recommended

The first point to note in Extract 7:12 is that, through her account, TC (the interviewee) illustrates inferences with potentially negative connotations when accounting for homeopaths. TC's 'troubles telling' talk portrays homeopathic practice as a sceptical, marginalised activity by talking about it in explicit terms (Jefferson 1984; Jefferson and Lee 1992). TC goes on to potentially defend an 'osteopath' (Line 11) by undermining the prior criticisms of the 'osteopath' (Line 11) in relation to 'witch doctor(s)' (Lines 4 and 8). TC accomplishes this by justifying and aligning osteopathic practice with medical training, which is the acceptable evaluative criterion used to measure credible practice. TC introduces the availability of the homeopath and having a huge back problem as personal factors in looking to homeopathy. By constructing her case in this way, TC is observed to be downgrading the credibility of the homeopath's practice in a culture of scepticism as a controversial and contested problematic out-of-the-ordinary alternative type of practice. The function of TC's strategy is to enhance the credibility of her practice in looking to homeopathy and counter the view that she may be discredited for doing so.

CC's utterance 'you mentioned the word marginalisation there (.) what do you mean by that?' (Lines 1-2) makes an explicit reference to the notion of 'marginalisation' (Line 1), suggesting that TC would be expected to respond accordingly and in alignment with such an inference. In an immediate response, TC claims, 'well it's to do with how society in general views homeopaths' (Line 3), suggesting that a footing shift has taken place. On this occasion, footing can also be understood as part of a more general issue of alignment and how far speakers are either presenting some factual account as their own or are distancing themselves.

Moreover, the communication being worked up in the treatment of events includes attributional issues and how they are handled. In her description, TC is constituted as merely reporting what any neutral, competent member of 'society' (Line 3) would know about homeopath(s) (Lines 3 and 10). By talking hypothetically on behalf of society's views in general, TC again makes it difficult to challenge because it is not necessarily her opinion, and this adds to the objectivity, factuality and authenticity of the claims being made. Therefore, TC attends to her personal accountability as someone who is just quoting what society has said to counter any potential challenges to her claims. TC is thus demonstrating the mutually intelligible, culturally shared notions of homeopaths.

TC follows this with a potential criticism: 'it's still seen as maybe a couple of steps up from witch doctor (.) type thing and there is a kind of grouping together with alternatives (.) alternative religions alternative thinking' (Lines 3-6). This portrays 'homeopaths' (Line 3) in relation to 'witch doctors' (Line 4) and as analogous with a wide range of alternative practices. Further, this segment of talk is constructed in a three-part format that indicates a general commonality to the notion of 'alternatives' (Line 5) by orienting to and building up matters that have an apparently analogous relevance. On this occasion, TC uses the three-part structure as a discursive device to achieve interactional persuasiveness and defend the situation against an impending discord (Jefferson 1990). TC goes on to qualify her claim by making relevant an assessment, 'I think that does kind of marginalise' (Line 7), that focuses on the apparent troublesomeness of the contingently formulated circumstances of being alternative (Jefferson 1984; Jefferson and Lee 1992).

Although TC talks about homeopathy in relation to the 'witch doctor' (Line 4) as something alternative and/or marginal, she spontaneously invokes the notion of

osteopathy as in alignment with alternative practice. TC is heard to be drawing on consensus and corroboration through a criticism, ‘certainly my own GP considers an osteopath to be just about up there with the witch doctors’ (Lines 7-8), attributing the evidence to the GP, as a way of working up consensus and corroboration as evidence (Horton-Salway 2001; Wooffitt 1992). The particle ‘just’ (Line 8) on this occasion is thus framed restrictively and is used to express that idea that the ‘osteopath’ (Line 9) is in alignment with the ‘witch doctors’ (Line 8) (Lee 1987). By talking about and spontaneously invoking the category of ‘osteopath’ in this sequence, TC tacitly displays the prevailing notion that it is acceptable to align ‘osteopath’ (Line 9) with ‘witch doctors’ (Line 9) in a similar way to the way in which she formulated the homeopath/witch doctor as in alignment in the prior utterance.

In a defensive orientation, TC produces a detailed account, ‘which is crazy because osteopaths obviously go through their five years or whatever of medical training’ (Lines 8-10), inferring that five years of medical training is an acceptable yardstick by which to evaluate the osteopath. In so doing, TC, through her talk, works to boost the credibility of osteopathy by aligning it with the acceptability of ‘medical training’ (Line 10). Note that TC portrays and substantiates the event and experience as something that is being reported, thus diminishing her own individual agency and in this way attending to accountability with respect to the inferences made.

TC aligns the homeopath with osteopathy, suggesting that in her assessment an osteopath is a type of homeopath: ‘the most recent homeopath I’ve used was an osteopath’ (Lines 10-11). TC follows this by providing material that introduces the personal factors involved in her looking to homeopathy: ‘I chose the homeopath for two reasons one she was available when I had a huge back problem and two because she was recommended’ (Lines 10-13). These attributes are heard as ways to justify

looking to the homeopath. The homeopath's availability and reference to a huge back problem serve to substantiate the objectivity of the event and suggests that, by offering these as resources at this part of her account, TC displays them as something that is being reported and thus again works to diminishes her own individual agency with respect to promoting her own credibility as a speaker.

By talking about homeopathy in this way, TC presents it as something controversial, contested and positioned in a culture of scepticism and as an out-of-the-ordinary alternative to mainstream medical practice. In producing this strategy, TC highlights the difficulties involved in making homeopathy credible but significantly manages issues in relation to her responsibility for her own personal credibility and accountability in looking to homeopathy.

Extract 7:13

1. CC: okay (.) okay ehh hmm (.) so why did you choose that particular
2. homeopath
3. Z: when I went in they just made you feel as though this is perfectly
4. normal whereas quite a lot of other people who I've spoken to were
5. like ohh (.) you're going to a homeopath that's is a bit kind of (.) and
6. kinda the circle of friends that we have (.) quite a lot of them are
7. ((name of person)) friends from medical school so there was a lot of
8. it's a load of rubbish blah blah blah (.) these alternative practitioners (.)
9. basically that I felt as though she was working as far as I could tell
10. quite a reputable clinic and she had those extra qualifications she was
11. quite happy for me to phone her up before I even made the
12. appointment

In Extract 7:13, Z (the interviewee) is working up his account through a defensive orientation of his practice to claim that attending the homeopath is a 'normal' (Line 4) mundane activity. The function of the strategy is to enhance the credibility of his practice. On the downside, however, Z presents potential criticisms of homeopathic practice by 'people' (Line 4) and '((name of person)) friends' (Line 7), attributed to as the source of potential confrontation. In building up credibility as a

reliable speaker, Z furnishes his account with the discursive resources available to deal with and attend to issues in relation to his personal accountability. In doing so, Z demonstrates how he deals with the objectivity, facticity and persuasiveness of his reported experience. On this occasion, the main characteristics of the account are provided by drawing on consensus and corroboration as evidence, by using reported dialogue via the deployment of active voicing, (Wooffitt 1992) the extreme-case formulation (Pomerantz 1986), and three-partedness (Jefferson 1984; Wooffitt 1992). These discursive devices are used to further justify his practice. In so doing, Z constructs to illustrate a problematic and troubled focus when describing a prior encounter with the homeopath (Jefferson 1984a; Jefferson and Lee 1992). The wider effect is to present homeopathy as a treatment with potential benefits, but the downside of such inferences is to position it as a contested and controversial out-of-the-ordinary practice.

CC's utterance, 'okay (.) okay ehh hmm (.) so why did you choose that particular homeopath' (Line 1), is designed specifically to elicit a response in reference to making a choice of the homeopath. Z responds with what is heard as defence, which is portrayed as a potential personal factor in looking to homeopathy: 'when I went in they just made you feel as though this is perfectly normal' (Lines 3-4). This displays an orientation to an apparent inner cognitive emotion. Z corroborates his evidence by invoking 'they' (Line 3), who are attributed to evoking a perceptual change in the circumstances presented and thus builds facticity into the claim. The use of the particle 'just' (Line 3) in this context is 'depreciatory' and functions to express an attitude and minimises the process of going to the homeopath—'made you feel as though this is perfectly normal' (Lines 3-4) (Lee 1987). Furthermore, if this event apparently felt 'perfectly normal' (Line 4) it infers that it may be formulated at

another time as abnormal, thus emphasising a potential problematic nature in attending a meeting with a homeopath.

This is immediately followed up with Z's work to build up a criticism: 'whereas quite a lot of other people who I've spoken to were like oh (.) you're going to a homeopath that's is a bit kind of (.) and kinda (.)' (Lines 4-5). This infers that attending the homeopath is indeed viewed as in some way contentious and potentially problematic. Z substantiates his accuracy as a speaker firstly by the deployment of an extreme-case formulation, 'quite a lot of people who I've spoken to' (Line 4), which is used as evidence to corroborate his claims. By stating 'quite a lot of' (Line 4), Z indicates the amount of people as significant. This proposes that it is an acceptable amount of people and friends to warrant the claim as authentic and subsequently factual. Z thus legitimises the claim by invoking an extreme-case formulation (Pomerantz 1986). Further into his account, Z claims, 'the circle of friends that we have (.) quite a lot of them' (Line 6), which is used in a similar way to work as an extreme-case formulation, working up corroboration and persuasiveness into the accuracy of the claims being made (Pomerantz 1986).

Here, however, to further construct credibility and facticity as an accurate and reliable speaker, Z utilises the inferential and corroborative activities of the active voice by invoking 'oh (.) you're going to a homeopath that's is a bit kind of (.) and kinda (.)' (Line 5). This infers a potentially negative attribution in relation to attending the 'homeopath' (Line 5). In so doing, the utterance is portrayed as if it was heard exactly like that at the time it was spoken (Wooffitt 1992).

Furthermore, in the deployment of the active voice, Z this time attributes it to the '(((name of person))) friends from medical school' (Line 7). Z invokes 'it's a load of rubbish blah blah blah these alternative practitioners' (Line 8), which is mobilised

to emphasise a criticism invoking potentially negative and sceptical properties of the inferences made concerning attending alternative practitioners. The significance of ‘((name of person)) friends from medical school’ (Line 7) adds persuasiveness to the consensus and corroboration of the events and portrays Z’s experience as objectively available to a number of people (Edwards & Potter 1992; Horton-Salway 2001). By upgrading the judgemental witnesses in relation to ‘friends from medical school’ (Line 7), Z demonstrates that the inferences were spoken by knowledgeable and potentially reliable others. Significantly, Z orients to the notion of the alternative practitioner as analogous with homeopathic practice and relevant to the interaction. Z thus makes explicit that the homeopath is alternative to notions of mainstream medicine and is presented in a contested and controversial fashion.

Moreover, the barest form of three-partedness is observable in the use of the triple singles ‘blah blah blah’ (Line 8) to emphasise and indicate a commonality in the considerable quantity of potentially negative inferences in relation to the homeopathic approach (Jefferson 1990).

Z follows this with what is heard as a further justification for looking to homeopathy—by offering personal factors. Z structures this element of his talk as a three-part list: first, as an assessment to promote and justify his practice as credible, Z offers, ‘basically that I felt as though she was working as far as I could tell quite a reputable clinic’ (Lines 9-10); second, as an upgrade, Z invokes ‘and she had those extra qualifications’ (Line 10) (more than this, both claims are a way of attending to homeopathy as a credible everyday practice); third, by making relevant ‘she was quite happy for me to phone her up before I even made the appointment’ (Lines 10-12), this portrays the homeopath as an obliging approachable kind of practitioner. By structuring his response in this way, Z defends his practice by demonstrating the

potentially positive features in relation to looking to homeopathic practice (Jefferson 1990).

Finally, in accounting through primarily a defensive orientation, Z's strategy works to enhance the credibility of his practice. In doing so, Z offers personal factors for looking to homeopathy as justification. By invoking the specific discursive features above, Z is delicately attending to his accountability as a reliable, competent speaker, just reporting the usualness and facticity of attending the homeopath. Consequently, homeopathy is portrayed as a practice positioned in a culture of scepticism, and as a contested and controversial knowledge claim, oriented to as a downgraded alternative to notions of mainstream medicine.

7.3.2 The 'alternative' as a 'private practitioner'

In the final Extract, 7:14, DW (the interviewee) talks about homeopathy in a similar way to the previous Extracts 7:9-7:13. Here, however, DW does not explicitly talk up homeopathy as 'alternative' but presents it as a contested and controversial practice made explicit as an 'alternative' in the way she contrasts it to the normative evaluative principle—to notions in relation to mainstream medicine. This way of accounting is seen below:

Extract 7:14

1. CC: yes (.) so (.) what feelings (.) did you get from the homeopath that you
2. used
3. DW: what feelings (.) I (.) I (.) he (.) made it very clear he had no idea that if
4. it could help me and it was very good of him to say that and (.) that it
5. would just be a long slog and it would have to go on and on and on (.)
6. if you are used to (.) if you are a child of the National Health Service
7. you are suspicious always with private practitioners you can't help
8. it (.) so it takes a lot of visits (.) so you going on paying and you don't
9. know if it's going to work and he doesn't know it's a difficult situation

10. you only do it if you are desperate so ehh (.) absolutely let's face it and
11. I was desperate
12. CC: hmm
13. DW: so I think he (.) ehh believed in what he was doing

In DW's account, she is observed to be deploying potential 'troubles-talk'. By invoking what are heard as personal factors in relation to her use of the private (alternative). Initially DW displays what is heard as explicit criticisms in relation to the 'private practitioner'. As a way of building-up persuasiveness, DW's talk is constructed in an elaborate form of three-partedness involving three-part units as components of the larger unit (Jefferson 1990). The first part of the activity sequence beginning, 'what feelings...' (Line 3) is set in a list format that contains a three-part activity (such as punning and acoustic consonance): 'on and on and on' (Line 5). Second, the utterance 'if you are used to...' (Line 6) is set in a three-part list format. The third component, 'so it takes a lot of visits...' (Line 8), is again set in a list format. All components are designed to emphasise the broad generality of the phenomena, which adds persuasiveness to the claims DW makes available to the interaction. As a discursive accomplishment, DW is seen to invoke potentially negative inferences by presenting potential criticisms directly in relation to issues of the 'private practitioners' (Line 7) practices. In doing so, DW talks up the private practitioner as a contested, controversial, problematic and troubled alternative, in contrast to the taken-for-granted evaluative yardstick for practice—the mainstream 'National Health Service' (Line 6). At the same time, DW's strategy works to enhance the credibility of her practice. By offering the personal factor 'I was desperate' (Line 11), DW defends her individual practice in looking to homeopathy as an out-of-the-ordinary practice.

In the first-part component of the three-part structure of DW's overall strategy, CC's utterance 'yes so what feelings (.) did you get from the homeopath that you

used' (Lines 1-2), is designed to elicit a response from DW with a reference to 'feelings' (Line 1) and the 'homeopath' (Line 1) as relevant to the interaction. Accordingly, DW orients towards a formulation that identifies one kind of experience, invoking 'what feelings (.) I (.) I (.) he (.) made it very clear he had no idea that if it could help me' (Lines 3-4) in a forthright way and as a potential criticism. By stating 'he had no idea' (Line 3), DW portrays and substantiates the 'other' as integral in the involvement of the prior interaction. In so doing, DW's utterance is designed to diminish her own individual agency as the sole person having the view that he might not be able to help and is an explicit way of attending to her own responsibility to accountability.

DW follows with a three-part sequence implicated with the 'poetics' of natural talk. Initially, DW invokes a potentially positive claim—'it was very good of him to say that' (Line 4)—as the first item in a three-part sequence suggesting the notion of approval was accepted by DW. However, the second item, a potential criticism—'and (.) that it would just be a long slog' (Lines 4-5)—infers that DW provides evidence of the ambiguity surrounding the length of time. Further, the particle 'just' (Line 5) on this occasion is 'emphatic' and functions to emphasise the notion of 'long slog' (Line 5). On this occasion, this interpretation is justified as most salient in the 'X after Y' or 'just be a...' (Line 5); hence, the 'emphatic meaning' should be regarded as contextually most appropriate (Lee 1987). The third item on the list, presented as 'and it would have to go on and on and on' (Line 5), contains a three-part rhythmical quality, specifically 'on and on and on' (Line 5) that has phonetics similar to the previous inference 'long...' in the prior segment of talk. The contrasting of 'long' (Line 5) and 'on and on and on' (Line 5) is used to work up and infer a potential criticism ambiguity surrounding a precise time period. By stating 'it was good of him

to say that' (Line 4), DW is implicit in the way she portrays the event as something that she experienced, and how she attends to and manages her personal accountability, countering any potential challenges to the claims she is making being heard as her direct criticism of the practitioner. This underpins the event as being presented as it happened and thus builds objectivity and facticity into the inferences presented (Wooffitt 1992).

The second component in the three-part structure of her strategy sees DW work up a further critical sequence, claiming 'if you are used to (.) if you are a child of the National Health Service you are suspicious always with private practitioners you can't help it' (Lines 6-8) as away of displaying the commonsense notions and scepticism surrounding practitioners outside the 'National Health Service' (Line 6). In doing so, Z makes explicit the contrast between the taken-for-granted yardstick for practice, the 'National Health Service' (Line 8), and the alternative 'private practitioner' (Line 7) as a way to evaluate medical practice. Significantly, on this occasion DW's inferences are constructed in a three-part list format to justify, add persuasiveness to and illustrate the commonality of the claims being made (Jefferson 1990).

Further, by claiming 'if you are a child of the National Health Service you are suspicious always with private practitioners you can't help it' (Lines 6-8), DW offers a potentially critical and sceptical view of 'private practitioners' (Line 7) and at the same time aligns herself as someone who apparently has an allegiance to the 'National Health Service' (Line 6). This is characterised by the way that 'child' (Line 6) and the 'National Health Service' (Line 6) infer that she has a long-term relationship with the NHS. In a similar way, DW aligns 'suspicious' (Line 7) as salient and relevant when referring to 'private practitioners' (Line 7). DW's 'you can't help it' (Lines 7-8) is

used to diminish her own individual human agency as relevant to the situation being described, and thus attributes her potentially negative and critical view of private practitioners as something any neutral and competent observer would experience in a similar situation (Wooffitt 1992).

The third component of the activity sequence in DW's strategy is used to deploy what is heard as a potential criticism in a list format to construct her argument as credible: 'so it takes a lot of visits (.) so you going on paying and you don't know if it's going to work and he doesn't know it's a difficult situation' (Lines 8-9). This articulates her apparent circumstances as situated in a long-term potentially problematic and troubled encounter.

This is emphasised further by the way DW portrays the excessiveness of the situation: 'so it takes a lot of visits' (Line 8). Here, 'a lot' (Line 8) is the proportion of the amount of times DW apparently visited the practitioner and operates to provide a sense that it was excessive and frequent. So 'a lot' (Line 8) is a device for attributing the cause of the problem to the object. This suggests an unreasonable and unacceptable amount of visits. In doing so, DW adds persuasiveness to the claim being made. This notion is followed by the assessment, 'so you going on paying and you don't know if it's going to work' (Lines 8-9), to add to the problematic nature of the encounter.

By making relevant 'he doesn't know' (Line 9), DW attributes corroborative evidence by invoking the 'other', who apparently observed the event in a similar way. This adds consensus to the claims and portrays neutrality, objectivity and authenticity to illustrate the accuracy of the events being described (Horton-Salway 2001; Wooffitt 1992). Finally, describing 'it's a difficult situation' (Line 9) can be heard as a consequence of the segment of talk that directly follows in the account. Significantly,

the upshot on this occasion allows the speaker DW to constitute reflexively the character of the prior segment of talk, which preserves the inferences regarding the potential difficulties between the 'private practitioner(s)' (Line 7) and DW. In so doing, the effect is that DW is heard to constitute the essential aspects of her prior utterances and transform or delete specific details to add persuasiveness to the claims being made (Wooffitt 1992).

DW then offers personal factors involved in looking to homeopathy. In what is heard as a further criticism, 'you only do it if you are desperate so ehh (.) absolutely let's face it and I was desperate' (Lines 10-11), the attributions serve to display DW in a potential state of vulnerability as an attribution to attending the private practitioner. DW's claim, 'you only do it' (Line 10), demonstrates the normativity of her actions, inferring that it is an appropriate way to behave in the situation described. The use of the repetition 'desperate' (Line 10 and 11) adds rhetorical strength to the potential criticisms. In making the assessment 'so I think he (.) ehh believed in what he was doing' (Lines 11-12), DW offers a defence to make her practice as a patient looking to homeopathy credible. Moreover, by accounting in this way, the claim works to counter any potential challenge on issues surrounding her personal accountability in looking to homeopathic practice. At the same time, it is how DW can be seen to justify and make credible her practices in the apparently continuing interpersonal relationship with the 'private practitioner(s)' (Line 7).

Finally, although DW does not make explicit in her talk that homeopathy is alternative, she presents it in a contrasting frame with notions of conventional medicine that offers this inference. On this basis, homeopathy is presented as a downgraded, problematic and troubled out-of-the-ordinary alternative to notions of conventional medicine.

7.3.3 Summary of the Analysis in Extracts 7:9-7:14

Throughout the managing-homeopathy-as-alternative strategy identified in the above extracts, I illustrate the ways in which the interviewees, through their social actions, introduce personal factors that present homeopathy as a problematic alternative ‘type’ of practice. At the same time, the interviewees account for their individual use of it. The function of the interviewees’ strategies is to enhance the credibility of their practices. In a similar way to the criticisms-of-medicine-to-justify-homeopathy strategy, notions of mainstream medicine are viewed as the taken-for-granted yardstick by which to evaluate medical practices. By presenting homeopathy as an explicit alternative on the fringes of mainstream medical practices, there are undoubtedly significant implications, with the wider effect being to potentially and continually marginalise homeopathic practice from mainstream acceptance—if one links the interviewees’ talk to broader social contexts (Wetherell 1998).

7.4 Discussion

In this chapter, the interviewees examined have built up inter-subjective sense-making practices produced through the interview setting. By applying a discursive approach as an analytical lens, it becomes apparent that there is no bottom line against which to measure the interviewees’ contingently formulated social practices. Rather than being considered as fixed views, the social actions *in situ* features of the multiple ways of accounting become the focus of enquiry. The ‘real life’ talk and subsequent accounts produced in the context of one-to-one interviews have been considered as performative, as social actions and as a topic of investigation in their own right.

Therefore, the analyses detailed above are specific to the research interview and to the hotly contested topic of homeopathy. The status of homeopathic knowledge is an accountability issue for the interviewees' and the analysis goes some way to support the claims about the function of their explanations as a way of enhancing their personal credibility. As a result, their credibility as competent patients looking to homeopathy is at stake.

In the institutionally constrained context of the research interview, CC's questions were seen to have a direct effect on the topics of discussion, and how the interviewees responded to and constructed their accounts depended on the contingency of the immediate situation. As anticipated, all the interviewees portray variation in their individual 'lay versions' of homeopathic practice. In alignment with chapter 5, the research interview was not treated as a tool to access accurate and truthful accounts; rather, the interviews are conceptualised as discursive accomplishments to explore the interviewees' communicative competencies and interpretative practices. Moreover, the interview is treated as a site of active interaction in which both the interviewee and researcher contribute to the content, shape and actions the talk is designed to perform (Potter 1996).

A further point to note is that not all the data collected from the separate interviews was included in the final analysis. The rationale being, discourse data tends to be rich therefore a particular discursive feature is identified to justify the broader argument. Essentially, the goal of analysis is to describe the organised trajectory of language use over broad strategies. It is for this reason I place emphasis on the examination of interactional strategies in contrast to a detailed analysis of the sequential context made available during the individual interviews in which they occurred.

Moreover, if all data examples were included and referenced to an even larger corpus of material the practicalities and organisation of such a quantity, would potentially make defining the analytical claims overly problematic.

Here, interviewees' ways of talking about homeopathic practice are grounded in defence of their practice, located historically and accepted culturally, and thus make particular notions of mainstream medicine relevant for consideration. None of the notions identified above are viewed as fixed entities; rather, they are constructed and constituted in situated interview settings. The downside is, however, to position homeopathic practice as an 'alternative' to wider notions of mainstream medical practices or as a practice that is problematic, controversial and contested as a knowledge claim. One way of viewing this is that it offers homeopathic practice as a 'last-resort-form' and 'type' of practice.

In their responses to being asked about their homeopathic practices, mainstream medicine goes largely uncontested as the interviewees negotiate, reassess and establish their accounts in relation to the taken-for-granted normative organising principle of mainstream medicine within the analytical scheme, which is undoubtedly an available omnipotent located social resource. In so doing, homeopathic practice is warranted on different grounds through the patterns of reoccurring features identified as discursive strategies.

The delicate discursive activities of the above two strategies serves to underpin the interviewees as attentive when they account for their everyday homeopathic practices in response to the requests made during the research interview. The interviewees rely on the introduction of particular descriptions or sets of descriptions representative of what is potentially a mutually intelligible, culturally available resource to constitute their homeopathic practices.

In the first strategy, ‘criticisms-of-medicine-to-justify-homeopathy’, homeopathic practice becomes presented through a defensive orientation and as a contested practice oriented to as an alternative to notions of mainstream medicine. To a certain extent these accounts rely on a range of ways of presenting their descriptions, which attribute looking to homeopathy through criticisms and the failures of mainstream medical treatments through ‘troubles telling’ talk (Jefferson 1984a; Jefferson and Lee 1992), which add persuasiveness to the benefits of homeopathy, or by adopting the (mundane) ‘X’ then (extraordinary) ‘Y’ device (Jefferson 1984; Wooffitt 1992). At the same time, a selection of their accounts represent the interviewees’ place within the proposed scheme by portraying themselves as ordinary people just explaining the ‘ordinariness’ of facts as they are (Sacks 1992; Stokoe and Hepburn 2005). Significantly, the use of such constructions is spontaneously and contingently formulated in their responses and not suggested to them in the preceding question from CC. In so doing, these ways of accounting, combined with various discursive devices, are designed to maximise the facticity and persuasive power of their interpersonal actions (Edwards and Potter 1992). The immediate attributional business works to counter the interviewees being seen as people with an axe to grind in terms of mainstream medical practice. Note that accountability becomes a central issue when they make their constructions heard as persuasive reportings. To counter any potential challenges, the interviewees are consistently focusing on diminishing any factors concerned with personal agency, working instead on increasing the objectivity of their talk.

It is also significant because this links to broader socio-political notions of what is inferred by references to mainstream medicine. By recurrently drawing upon a medical/homeopathic practice dyad presented in a comparative frame, the

interviewees sustain homeopathic practice as a downgraded alternative option. When accounting for homeopathic practice, this framework is then used to justify, argue for and legitimise conventional medicine as the taken-for-granted, accepted yardstick for practice in everyday settings. Therefore, the wider socio-political implications indicate that homeopathic continues to be demarcated, marginalised and positioned on the fringes of the medical environment basis and that homeopathic practice is continually void of a persuasive political voice.

Similarly, in the second strategy, 'managing-homeopathy-as-alternative', interviewees present homeopathic practice in a defensive orientation as something that is contested, controversial and out of the ordinary. The interviewees introduce personal factors that offer homeopathy as an explicit alternative type of practice and that account for their individual use of it. The range of methods that the interviewees use involve deploying 'troubles telling' talk (Jefferson 1984a; Jefferson and Lee 1992), contrasting homeopathy with conventional medical practices, combined with various discursive devices used to talk up the persuasiveness of the authenticity of the social actions being performed (Edwards and Potter 1992). By using the descriptions that they do, the interviewees enhance the credibility of their own individual practices and attend to the accountability as a discursive practice. For them, however, individual credibility is accomplished only through specific constructions of homeopathy that orient to it as a sensitive practice that continually marginalises it in terms of mainstream acceptance.

This activity is accomplished by contrasting homeopathy with notions of conventional medicine and medical discourse. What is demonstrated here is how the interviewees, through flexible use of the discursive resources made available, frame everyday homeopathic practices as problematic during social interaction. The

personal standpoints taken are constructed from available discursive resources that are contingently produced, negotiated and reworked to serve specific rhetorical functions that are wholly dependent on the situated rhetorical business at hand.

From a ‘top-down’ perspective, and in alignment with chapter 5, the downside is that by constructing their accounts in this way the interviewees’ social actions work to continually marginalise homeopathy (Wetherell 1998). Drawing on the Foucauldian (1980) notion of marginalisation—the ‘scientific’ institution as a metaphor—to constitute the ‘what is’ and ‘what is not’ wider scepticism about the validity of homeopathic practice, marginalisation is present when a dominant majority is at the centre of the legitimisation of the institution (mainstream medical practice, with diverse marginalised practices represented at the periphery—homeopathic practice as an ‘alternative’ type of practice). The boundaries of the institution are defined by ‘acceptable practices’ which are negotiated, resisted and made relevant by the mutually intelligible members’ methods of sense making. The notion of what is an acceptable, taken-for-granted or ‘normative’ practice is socially constructed and constituted over multiple discourses. In other words, through their talk, participants rely on historically formed and culturally shared meanings and expectations when (re-)producing intelligible accounting practices and actions. In so doing, the discursive effect of marginalisation varies between interactional contexts and settings. The findings show that the development that configures and sustains medical discourse as dominant truth claim/scientific knowledge/metanarrative is a socio-political, historically informed production and not a socially neutral phenomenon. Therefore, homeopathic practice is potentially and continually marginalised in terms of mainstream acceptance when presented in a contrast structure with categories in relation to homeopathy/mainstream medical practices (Wetherell 199

Chapter 8

Talk in the Homeopathic Consultation: criticisms-of-medicine-to-justify-homeopathy, boosting-the-credibility-of-homeopathy, and managing-homeopathy-as-alternative

Here, in the final analytical chapter, I examine, in the context of the homeopathic consultation, how practitioners and their patients manage individual credibility through and over three broad strategies. In so doing, three strategies from the preceding analytical chapters are made relevant and deployed throughout the consultative process. In this context, the participants' talk is viewed as naturally occurring, that is, it is uninterrupted by the researcher and it takes place in a formal institutional context. However, in alignment with previous analytical chapters, I demonstrate that working to enhance their individual credibility and attending to personal accountability is accomplished only through specific ways of accounting that orient to sensitive practices that work to potentially and continually marginalise homeopathy from mainstream acceptance.

First, I show how the features of sequence organization of the medical consultations are compiled into particular activities, which, finally, compose the interaction as a whole. Second, I discuss the criticisms-of-medicine-to-justify-homeopathy strategy where, through potential criticisms, the participants describe the failures of conventional medicine that justify looking to homeopathy.

Third, in the boosting-the-credibility-of-homeopathy strategy, homeopathy is presented as a practice that is potentially effective as a form of treatment when contrasted to conventional medicine.

Fourth, through the managing-homeopathy-as-alternative strategy, the participants introduce personal factors that offer homeopathy as a contested, controversial, problematic, out-of-the-ordinary, alternative type of practice and account for their individual use of it.

Finally, I illustrate that the individuals who use homeopathy are responding with particular actions to counter the possibility that they might be viewed as being discreditable. By accounting in this way, the participants' social actions work to enhance their own practices as credible and deal with the accountability of their talk. On a broader socio-political, historical and cultural context, the effect of the discourse is to potentially and continually marginalise homeopathy in terms of mainstream acceptance.

8.1 Interactional Elements of Medical Consultations

Heritage and Maynard (2006) have outlined what has come to be the standard sequence organizing sequencing of the typical medical encounter in practitioner / patient interactions. The overall structural procedure is:

I. Opening: the doctor and patient establish a relationship, II. Presenting problem and history taking: the patient presents the problem and the reason for the visit, III. Examination: the doctor conducts a verbal and often concurrently a physical examination, IV. Diagnosis: the doctor evaluates the patients condition, V. Treatment: the doctor details the treatment or further investigations, and finally VI. Closing: the consultation is terminated. The overall structure is not generally sequentially interchangeable. Notably the opening and closing organization is likely to be

sequentially fixed. However, there are exceptions when a patient recalls a relevant piece of information once the interactive process is underway. On these occasions previously explored activity phases may be revisited. This is achieved as a recursive process within the constraints of consultation expectations and norms. Routinely, however, a practitioner is likely to try and structure an ordinary consultation in the normative order given. The data I had underpinned the structural framework available for medical consultations. However, I did not intend to represent and examine the routine consultation. For this present study I examined the broad discursive strategies relating to the non-sequentiality within the homoeopathic consultation. Examples of my approach are explicated below.

8.2 The Criticisms-of-medicine-to-justify-homeopathy Strategy

In the first discursive strategy identified, the participants account for and defend their orientation to homeopathy by criticising the failure of conventional medicine. The speakers demonstrated their orientation to the notion of this strategy, which was also observed in the patient data in Chapter 5. With reference to that chapter, patients were shown to be responding to requests from CC in the context of the research interview.

Here, in more formal institutional setting, this particular strategy is achieved over a range of ways by criticising and undermining medical approaches through ‘troubles telling’ talk (Jefferson 1984; Jefferson and Lee 1992), combined with various discursive devices to maximise the persuasive power of their potentially factual descriptions and social actions being performed. The function of their strategies is to enhance the credibility of their practices while at the same time

attending to interactional issues in relation to personal accountability and to build up their claims as factual.

8.2.1 Talking Up Potential Criticisms

In Extracts 8:1 and 8:2, the participants are observed to be talking about homeopathy from the perspective of treatments. In Extracts 8:3 and 8:4, the participants are talking about homeopathy from the perspective of attending the homeopathic consultation. A related point is that on all occasions the participants are observed to be orienting towards a ‘last-resort-form’ and ‘type’ of practice in their own particular ways. These ways of talking about homeopathy and subsequent accounting are seen in the context of the homeopathic consultation in the extracts below:

Extract 8:1

1. BH: how can I help
2. SV: mm (.) like I always say I fight with my skin because I seem to have
3. this constant problem with my skin (.) I scratch myself it doesn't seem
4. to be any specific skin condition because I've been to various er (.)
5. dermatologists and it's never been classified as a specific thing (.) it
6. seems to be something related to =
7. BH: = so dermatologists have given you creams and things like that =
8. SV: = yeah (.) I tried that
9. BH: okay
10. SV: used it for a while and I gave up because they weren't doing
11. anything in particular so I used homeopathy (.) hmm

Here, the sequence occurs near the beginning of the consultation. BH (the practitioner) is attending to the patient's (SV) potential ‘troubles telling’ in relation to her experience of previous failed medical treatment (Jefferson 1984; Jefferson and Lee 1992), which is used as a justification for looking to homeopathy. SV cites skin

problems as the focus of her presenting problem, to which BH offers a criticism concerning the treatments dermatologists would offer. SV is heard to look to homeopathy on this basis. So the function of BF and SV's strategies is to enhance the credibility of their practices.

In so doing, both BH and SV construct their talk to justify looking to homeopathy, which is presented in relation to the apparent failure of medical treatment. At the same time, SV attends to and manages issues in relation to personal accountability by attributing criticisms and the failure of mainstream medical approaches to dermatologists and the creams they offered and not as SV being someone who looks to homeopathy on a whim. Thus, the ways that BH responds indicates that SV's orientations are a possible normative occurrence in this type of practitioner/patient interaction—that is, by presenting homeopathy as a 'last-resort-form' and 'type' of practice in the context of the institutionally informed consultation.

BH begins by formulating a request 'how can I help' (Line 1) as a design which leads towards a problem focus. Using the resource, 'help' (Line 1), evokes the notion of there being many options that BH can offer. In doing so, BH is attending to SV's troubles and the normative role of practitioner. Accordingly, SV, through 'troubles telling', constructs a potential criticism by describing; 'mm (.) like I always say (.) I fight with my skin because I seem to have this constant problem with my skin I scratch myself' (Lines 2-3), which works to present how she views and resists her disposition and what apparent actions she takes to alleviate the condition by citing, 'I scratch myself' (Line 3) as relevant to the interaction for consideration. SV thus displays how she constructs an attentive awareness about her health by highlighting a physiological factor to her problem.

SV, by making relevant ‘like I always say’ (Line 2), portrays a description of the prevalence of the practice of talking about her condition on a regular basis. Being heard like a defence formulates the occurrence as frequent and as such, used to present her claim as a routine sequence of events. Moreover, SV describes the precipitating situation in terms of the frequency, ‘constant’ (Line 3), which proposes a regular and continuous problem. In so doing, SV attributes the cause of the problem to the object, ‘skin’ (Line 3), and on this basis is presenting an argument to add persuasiveness to the claim being made. Furthermore, by making relevant, ‘I scratch myself’ (Line 3), SV’s claim works to provide details of a normative behavioural reaction to having a constant problem with her skin. The effect is to manage the potential medical complaint and justify her actions and practices as credible.

SV follows this immediately with a potential assessment of her condition—‘it doesn’t seem to be any specific skin condition because I’ve been to various er (.) dermatologists and it’s never been classified as a specific thing (.) it seems to be something related to’ (Lines 3-6)—that portrays her condition as something numerous dermatologists have found problematic. Significantly, SV’s claims are set out in a potentially problematic three-part sequence; that is, BH interrupts SV before she can add a third item to complete the list in her assessment of her condition (Jefferson 1990).

The first item is an assessment described as, ‘it doesn’t seem to be any specific condition’ (Lines 3-4), which works to imply the ambiguity of the condition. The second item, talked up as a potential assessment of the condition, ‘I’ve been to various er (.) dermatologists and it’s never been classified as a specific thing’ (Lines 4-5), is portrayed as an ordinary everyday event that happened to SV. More than this, it presents SV as taking the appropriate action in the context of the surrounding

conversational activities. This is corroborated with evidence from the ‘dermatologist’ (Line 5), who apparently could not categorise the condition over significant visits. Third, by claiming that ‘it seems to be something related to’ (Lines 5-6), SV formulates what is heard as a potential consequence of the two prior utterances in the three-part sequence. By constructing her response in three parts, SV works to build evidence to portray some constant but ambiguous features of experiencing the skin problem (Jefferson 1990; Wooffitt, 1992). In doing so, SV talks up her presenting problem as part of the normativity of practitioner/patient interaction when she consults for answers to the presenting complaint.

Immediately and spontaneously following this, BH interrupts SV and invokes a request, ‘so dermatologists have given you creams and things like that’ (Line 7), which is projected as a continuation of the inferences made by SV’s three-part formulation. Here, BH is offering a potential alignment between SV’s initial presenting complaint and the usual treatment options in relation to the dermatologist—‘creams and things like that’ (Line 7). Consequently, BH shows affiliation with SV but works to preserve her experience as the focus of attention.

In response, SV produces a potentially positive acknowledgement, ‘yeah (.) I tried that’ (Line 8), as a way of affiliation and of what is heard as a first item in another three-part sequence. This orientation displays SV’s action and efforts to find a solution to her condition. Next, BH invokes ‘okay’ (Line 9) as a minimum acknowledgement, either indicating that SV should continue to talk without interruption or as a way of attending to the strategy of encouragement in the consultation context.

Accordingly, SV continues to construct the last two items on the list and refers explicitly to her own equivalent experience, ‘used it for a while’ (Line 10), as an

appropriate way of emphasising that a continuous effort was carried out over an unspecified period. The last item, ‘and I gave up’ (Line 10), is used to justify and endorse her action as appropriate. The notion, ‘because they weren’t doing anything in particular’ (Lines 10-11), can be heard as SV’s characterisation attributed to the apparent criticism and subsequent failure of medicine—‘creams and things like that’ (Line 7). In proposing the critical ‘they weren’t doing anything’ (Lines 10-11), SV orients to the situation in terms of the level of accomplishment being potentially unacceptable. This, in turn, merits a potential to justify looking to homeopathic practice. On this occasion, the deployment and use of ‘anything’ (Line 11) is attributable to the object, ‘creams and things like that’ (Line 7), and is heard as an extreme-case formulation as a way of building up a justifiable and persuasive argument (Pomerantz 1986).

Finally, SV works up an explicit reference to what is heard as an upshot and as a justification for looking to homeopathy: ‘so I used homeopathy (.) hmm’ (Line 11). This indicates that her behaviour and portrayal of a cognitive decision are attributed to the preceding claims. By accounting in this way, SV talks up the event and, at the same time, relies on various social actions and discursive devices to manage and attend to her personal accountability concerning the claims being made.

SV thus portrays homeopathy as a treatment option looked to in relation to the criticised failure of medicine. Moreover, the discursive design of SV’s strategy is to talk up homeopathy as a practice oriented to after such a potentially negative experience of mainstream medical treatments.

Extract 8:2

1. CW: did you have any other tests at the same time
2. BF: when (.) I did the B12
3. CW: thyroid or anything

4. BF: yeah (.) I did thyroid yeah everything is fine (.) I used to have it in the
5. past oh (.) right talking about throat yeah erm (.) mm yeah in the past
6. when I was very young I was twelve thirteen I had hyperthyroidism (.)
7. well slightly
8. CW: uh (.) hum
9. BF: I took ehh (.) no (.) well anyway I took thyroxin for a few years to no
10. avail so I never understood it anyway (.) but then I went to
11. homeopathy and ehh (.) mm
12. CW: right
13. BF: and then I gave up taking these drugs

This section of transcript in Extract 7:2 (with BF the patient and CW the practitioner) occurs during an apparently biographical/narrative ‘troubles telling’ sequence (Jefferson 1984; Jefferson and Lee 1992). The action is taken from about halfway through the consultation. The discussion relates to CW’s collecting information regarding BF’s apparent failed past during talk about her medical history. BF, through a defensive orientation of her practice, constructs and orients to relevant information regarding previous medical tests and her illness disposition. BF is explicit in the way she justifies using homeopathy, which she attributes to criticism after receiving medicine in the form of ‘thyroxin’ (Line 9) and its subsequent failure. This implies that prior medical treatment was apparently of little medicinal or therapeutic value. In a similar way to SV (Extract 7:1), BF talks up homeopathy as a ‘last-resort-form’ and ‘type’ of practice when criticising prior medical treatments. The function of this strategy is to enhance the credibility of their practices through an everyday homeopathic encounter and at the same time manage personal accountability.

CW’s utterance, ‘did you have any other tests at the same time’ (Line 1), portrays an orientation towards eliciting a response from BF in relation to potential medical investigations. This demonstrates that CW is attending to BF’s ‘troubles telling’. In an immediate and spontaneous response, BF offers ‘when (.) I did the B12’ (Line 2), which is designed as a request to clarify the prior inference from CW

regarding the specifics of a B12 investigation. CW offers the specific option of ‘thyroid or anything’ (Line 3) as a way to indicate that any memory recollection available to BF can be cited as relevant evidence to the interaction. BF follows this immediately with an assessment ‘yeah (.) I did thyroid yeah everything is fine’ (Line 4) as a preferred response, which serves to reinforce the notion that ‘everything’ (Line 4) is fine. By invoking ‘everything’ (Line 4) in this context, BF attributes the cause to the object, ‘I did thyroid’ (Line 4), which is used to persuade CW of the proportional measure of ‘everything’ (Line 4) and how something should be regarded as ‘fine’ (Line 4). By describing the phenomenon as ‘everything’ (Line 4), BF attributes the completeness of ‘fine’ (Line 4), and this is heard as an extreme-case formulation (Pomerantz 1986). This is also the case owing to the fact that if that was so, that is, ‘everything is fine’ why would BF begin an account of having to take thyroxin which effectively did not work. In addition, BF portrays and warrants the factual status of the inferences made by describing the accuracy of a past event, which works to build up her report as an objective experience (Wooffitt 1992).

However, a further ‘troubles telling’ sequence succeeds this segment of talk. BF formulates an event regarding her health status, ‘I used to have it in the past’ (Lines 4-5) as a recollection of an unspecific event, which infers that she had a disposition recognisable as ‘thyroid’ (Line 4). BF then goes on to invoke specific details of her case recognisable as potentially thyroid. BF tells, ‘oh right talking about throat yeah erm (.) mm yeah in the past when I was very young I was twelve thirteen I had hyperthyroidism (.) well slightly’ (Lines 5-7), which can be heard as a presentation of an illness characterisation which is followed with precise details. By recalling in this way, BF orients to the anatomy of the throat as an indication of hyperthyroidism. Furthermore, BF provides material for being a specific age—‘I was

very young I was twelve thirteen' (Line 6)—at the time the 'hyperthyroidism' (Line 6) as apparently prevalent. This serves to warrant the activities and circumstances as credible by providing accurate and detailed evidence. Claiming 'well slightly' (Line 7) offers a downgrade in relation to 'hyperthyroidism'. Also, it invokes a formulation to indicate that BF's 'hyperthyroidism' was potentially not as significant and accurate a description of the illness disposition.

At this point in BF's account, CW is observed to be invoking minimal acknowledgements, 'uh (.) hum' (Line 8) and, near the end of the account, 'right' (Line 12), as a way of indicating that BF should continue talking without interruptions, which is a normative activity for practitioners (Wooffitt 1992). BF continues to work up what is heard as a potential criticism in relation to thyroxin (conventional medicine): 'I took ehh (.) no (.) well anyway I took thyroxin for a few years to no avail' (Lines 7-8). This identifies a significant time period in which BF displays apparently unsatisfactory results. By invoking the perspective, 'so I never understood it anyway' (Line 10), BF designs her criticism to emphasise the apparent ambiguity in relation to 'thyroxin' (Line 9). Immediately following this, BF goes on to describe an event which is attributed to the prior disenchantment with 'thyroxin' (Line 9)—'but then I went to homeopathy' (Lines 10-11)—and thus the event is portrayed as being in some way responsible for BF's reference to looking to homeopathic treatment. In no way explicitly connected to homeopathic treatment, BF makes relevant what is heard as a conscious and perceptual change, 'and then I gave up taking these drugs' (Line 13), as a way of referring to the activity and behaviour of no longer taking 'thyroxin' (Line 9). In doing so, BF is observed to be defending her practice of orienting to homeopathy. Significantly, and in alignment with Extract 7.1, BF orients to the notion of homeopathy as a 'last-resort-form' and 'type' of practice.

Extract 8:3

1. PP: this is my husband MP
2. DH: take a seat for me (.) so have you come along ((to the homeopathic
3. consultation)) from the advice from your doctors or is it just off your
4. own backs
5. PP: no my own back ehh (.) mm basically doctors can't they just say they
6. won't give you anything for it (DH: mhm (.) mm) but it's really
7. extreme (.) ehh morning sickness I'm sick all day (DH: um) ehh um
8. even drinking fluids are making me sick (.) so I've come to keep that
9. down so (.) basically I need some help
10. MP: ehh (.) mm I phoned one doctor's surgery and they said at this
11. stage they wouldn't give anything to stop the sickness

The first point to note is the segment of talk taken at the beginning of the consultation. There are three people involved in the interaction: PP, the patient and potential beneficiary of homeopathic treatment; DH, the practitioner; and MP, the husband of PP. Here, PP opens the interaction. DH immediately follows by offering the couple the opportunity to comment on the implications of attending the homeopathic consultation. Accordingly, in a defensive orientation to add credibility to her practice, PP performs the interactive business of 'scene-setting' by constructing a potential 'troubles telling' in relation to an apparent voicing of her criticisms in relation to a potentially negative encounter with a doctor. More than this, PP constructs the physiological difficulty of morning sickness as relevant to the presenting problem that led to this type of homeopathic consultation.

Further into the interaction, MP is observed to be working up the authenticity of PP's claims by corroborating her account through assigning and providing his own form of evidence to support her claims. So both PP and MP work to support the notion that they are attending the (homeopathic) consultation because of the critical failure of doctors to offer 'anything' (Lines 6 and 11). By accounting in this way, all the participants, PP, DH and MP, are heard to orient homeopathic practice as a 'last-resort-form' and 'type' of practice. The function of PP and MP's strategy is to

enhance the credibility of their practice as patients doing what any neutral competent observer would do in a similar situation. As a way of managing their personal accountability, PP and MP portray their talk as having no stake in promoting homeopathy and no axe to grind in relation to the doctor.

The interactional sequence opens with what is heard as an introduction. PP adds 'this is my husband MP' (Line 1) as a way of performing an introduction to DH. Immediately following this, DH initially formulates what is characterised as an invitation in this context, 'take a seat for me' (Line 2). However, at this point DH goes on to work up what is heard as a request; 'so have you come along ((to the homeopathic consultation)) from the advice from your doctors or is it just off your own backs' (Lines 2-4). In a spontaneous way, this invocation makes the notion of attending the 'doctors' (Line 3) in contrast to 'off your own backs' (Lines 3-4) relevant as a range of discursive resources available, and minimises the potential response from PP and MP. In stating 'have you come along from advice from your doctor' (Line 3), DH invites speculation that PP and MP conducted the activity of visiting a doctor prior to attending the present consultation. In doing so, DH presents his talk in a contrasting structure between the categories of medicine and homeopathy in this apparently normative context.

The citing of the particle 'just' (Line 3), on this occasion is 'depreciatory' and functions to minimise significance by downplaying the comparison of the process of attending the homeopathic consultation (Lee 1987). DH thus embroiders the unremarkableness and normativity of the inferences made regarding the attendance of the consultation: 'just off your own backs' (Lines 3-4) suggests that to conduct yourself in such a way is potentially typical for a practitioner of homeopathy.

PP responds immediately and spontaneously with a segment of talk designed to promote her own individual agency in the ‘cognitive’ decision to attend, ‘no my own back ehh (.) mm basically doctors can’t they just say they won’t give you anything for it’ (Lines 5-6), suggesting that she is working up a potential criticism directed at the doctor. Moreover, this implies that she indeed had a prior experience with a doctor, which is construed and displayed as a potentially motivating factor for looking to homeopathy (Wooffitt 1992). On this occasion, ‘just’ (Line 5) is ‘restrictive’, where PP makes a contribution to the propositional meaning of what doctors say and thus promotes the idea of limitation (Lee 1987). In addition, PP’s ‘anything’ (Line 6) is used in a defensive orientation, which contributes to her assessment of attending the consultation. In proposing that doctors cannot give ‘anything’ (Line 6), PP describes the circumstances and doctors’ actions as proportionate and thus ‘anything’ (Line 6) is recognisable as an extreme-case formulation, which adds persuasiveness to the claims being made (Pomerantz 1986).

PP’s evidence is being constructed here and warranted by the reported interaction between her and a doctor, which is a way that facticity, authenticity and credibility are portrayed as an accurate representation of social activity. Furthermore, in referring to ‘basically doctors can’t they say’ (Line 5), PP does not portray any sense of her action and own individual agency. Rather, it is attributed to an experience of an event that actually happened with a doctor (Wooffitt 1992). More than this, the experience is corroborated with the invoking of the ‘doctor’ (Line 5) adding persuasiveness to her practice as credible in looking to homeopathy.

PP constructs a case to present the implications of the attribution of the apparent physiological condition ‘but it’s really extreme (.) ehh morning sickness I’m sick all day even drinking fluids are making me sick (.) so I’ve come to keep that

down' (Lines 6-9) as an upgrade to emphasise the level of her poor health status. This medical complaint provides an illustration of how badly she is affected by the adverse situation of 'morning sickness' (Line 7) and, at the same time, demonstrates her action and efforts to overcome her condition. PP assembles her account with extreme-case formulations—'it's really extreme' (Lines 6-7) and 'I'm sick all day' (Line 7)—that are used to substantiate the disproportionate circumstances and subsequent behaviour attributed to any 'normal' form of morning sickness (Pomerantz 1986). The relatively ordinary and essential activity of drinking is portrayed as having a restrictive effect—'even drinking fluids are making me sick' (Line 8)—that increases the detrimental threat attributed to the morning sickness. As potential remedial action, PP invokes, 'so I've come to keep that down' (Lines 8-9), which works as a defence to mitigate responsibility for her condition and infers her expectation of a potential solution from DH. PP thus effectively attends to and manages the following request in relation to the prior claims: 'so (.) basically I need some help' (Line 9) is a justification to DH to attend to the issues above. Throughout this segment of talk, DH provides 'mhm (.) mm' (Line 6) and 'um' (Line 7) as minimal continuers that offer PP tokens of acknowledgement and affiliation to indicate that what PP is saying is recognised as potentially relevant to the interaction (Wooffitt 1992).

At this stage in the account, MP, in co-constructing in alignment with PP's views, offers a revealing potential criticism: 'ehh (.) mm I phoned one doctor's surgery and they said at this stage they wouldn't give anything to stop the sickness' (Lines 10-11). The inferential effect is twofold. First, MP claims to have contacted a doctor's surgery to reinforce the co-implicative details of the apparent inferences made: 'they said they wouldn't give anything' (Line 11). In the context of the account, MP's 'anything' (Line 11), which is positioned in similar lexical components

to PP's, works in a comparable way. MP's 'anything' (Line 11) works persuasively to provide a criticism and a sense of the lack of treatment offered by the doctor 'to stop the sickness', which minimises the value of support. Therefore 'anything' is an extreme-case formulation used to justify that the proportion of what the doctor's surgery offered was an unacceptable minimum (Pomerantz 1986). Second, the deployment of 'doctor's surgery' (Line 10) works as consensus and corroborative evidence to support PP's case and construct the persuasiveness of the claims and social actions being performed (Horton-Salway 2001).

By accounting in this way, homeopathy is constructed and oriented to by DH, PP and MP as a practice in relation to a potential criticism after receiving apparently unsatisfactory minimal assistance from doctors. Furthermore, it is constructed as the last-resort-form' and type of practice, since PP and her husband effectively exhausted all routs offered by conventional medicine.

Extract 8: 4

1. DH: it must be quite worrying for you at the moment
2. MP: (.) this morning ((referring to PP)) she managed probably ((vomiting in
3. background)) three or so lemonades
4. DH: mhm
5. MP: once she had taken all the gas out of it and she's been fine for the last
6. two or three hours (.) at the ((name of clinic)) clinic the doctor seemed
7. to say you have to get through it yourself they were not prepared to do
8. anything (.) and if it gets to the stage when you dehydrate we'll take
9. you into the hospital we'll still not give you anything for the nausea
10. DH: ehh
11. they'll sort of keep you alive but not ease your suffering (.) I suppose
12. there are a number of natural remedies but (.) the problem is if you if
13. you're nauseous (.) you can't really take them because the minute you
14. take it it's going to come straight up
15. DH: mhm (.) well we can use homeopathic remedies

The first point to note in Extract 8:4 (taken in the middle of the consultation) is that initially DH (the practitioner) and MP (the husband of PP) are negotiating with

regards to PP's disposition. In constructing potential criticisms in relation to medicine, MP is offered homeopathic remedies from DH, which positions homeopathy as a practice with potential benefits. In addition there are parallels, in what MP's and DH's joint construction accomplishes, with what PP provided as evidence in Extract: 8:3: that is, MP, through a defensive orientation of his practice, is reiterating some of the critical features in relation to attending the doctor who, as in PP's accusation, is apparently not prepared to do anything. MP talks up PP as someone who is taking appropriate actions to deal with the physiological aspects of her medical complaint. However, MP goes on to work up a potential criticism of medical practices in relation to what is presented as potentially negative behaviour from the doctor: 'they'll sort of keep you alive but not ease your suffering' (Line 11). A significant feature of MP's account is that it is structured in an elaborate and complex form of three-partedness involving three units that each offer a specific perspective to the overall strategy as MP and DH co-construct a case to justify homeopathic use. The function of the strategy is to enhance the credibility of their practice and at the same time manage the facticity and personal accountability of the reported events.

In the first unit of the three-part sequence, the action begins with DH formulating a request, 'it must be quite worrying for you at the moment' (Line 1), inferring that MP is experiencing elements of emotional distress in relation to aspects of distress as a perceptual state. At the same time, DH can be observed as displaying the notion of compassion as a practitioner in this context. In response to this, MP works up a potential portrayal of PP's circumstances, behaviour and disposition—'this morning ((referring to PP)) she managed probably ((vomiting in background)) three or so lemonades (DH: mhm) once she had taken all the gas out of it and she's

been fine for the last two or three hours' (Lines 2-4)—as a way of promoting PP as taking relevant action. By reporting in this way, MP's description works to preserve the notion that PP behaved in a way to promote self-help, which is reinforced with the justification, 'she's been fine for the last two or three hours' (Line 4) (Wooffitt 1992).

In the second unit of the three-part sequence, MP goes on to reference and portrays the potential unhelpfulness and inability of the doctor. He offers a potential criticism of medical practices: 'at the ((name of establishment)) clinic the doctor seemed to say you have to get through it yourself they were not prepared to do anything (.) and if it gets to the stage when you dehydrate we'll take you into the hospital we'll still not give you anything for the nausea (DH: ehh) they'll sort of keep you alive but not ease your suffering' (Lines 4-9).

In the telling, MP illustrates a range of inferential activities mediated using utterances that have been designed so that they are heard as the active voice of the doctor—such as 'you have to get through it yourself' (Lines 5-6). This quotation portrays the apparent lack of support associated with the doctor at the clinic which can be heard as criticism. A further critical orientation, 'if it gets to the stage when you dehydrate we'll take you into the hospital we'll still not give you anything for the nausea' (Lines 8-9), is used to furnish the apparent inability and limitation offered by the doctor. By employing the voice of the doctor, MP corroborates and warrants the accuracy of the speaker's description as a factual portrayal of events that were heard exactly like that at the time (Wooffitt 1992). A further feature is the way that MP works up a potential consequence, 'they'll sort of keep you alive but not ease your suffering' (Lines 11), which works as a criticism of medical practices, inferring a lack of compassion from the doctor. This is heard as potentially proportioning

dissatisfaction of the practice, inferring that the doctor's trajectory is to preserve life but not acknowledging the emotional disposition of the 'suffering' (PP).

In the final unit of the three-part sequence, MP's formulation—'I suppose there are a number of natural remedies but (.) the problem is if you, if you're nauseous (.) you can't really take them because the minute you take it it's going to come straight up' (Lines 11-14)—is designed as a rhetorical question to prompt DH to respond with a potential solution. Initially MP is heard to correlate 'a number of natural remedies' (Lines 12) in contrast to the prior utterance. This is followed by 'but (.) the problem is' (Line 12), which is heard as a compromise in the form of a disclaimer. Here, the disclaimer is used to ward off any possibly negative attributions in the utterance being made concerning 'natural remedies' (Line 12), and thus manages the business of heading off this possible counter challenge (Hewitt and Stokes 1975). Immediately after this, however, DH produces an invite 'mhm (.) well we can use homeopathic remedies' (Line 15), which is construed as a potential solution to MP's criticisms. At the same time, it is how joint construction is performed in this situation as a way of justifying looking to homeopathy, and serves to substantiate the objectivity, credibility and authenticity of the experience (Wooffitt 1992). At the same time, MP attends to his personal accountability by constructing himself as someone who had a negative experience with the doctor but is in no way biased towards medicine. However, the doctor's practice was criticised as a potential justification for looking to homeopathy. Again homeopathic practice is oriented to after a potentially critical and negative experience with the doctor.

8.2.2 Summary of Analysis of Extracts 8:1 - 8:4

The participants describe in their own way the criticisms and failures of mainstream medicine practices as a valid and justifiable basis for looking to homeopathy. As demonstrated above, the function of the strategies is to enhance the credibility of their practice and attend to the facticity of their claims. The participants are observed in the context of the homeopathic consultation to orient to and make relevant their own categories in a contrast structure between medicine and homeopathy. In doing so, the participants adopt various rhetorical devices to maximise the persuasive power of their potentially factual descriptions and work to make their talk and practices credible.

The participants, by accounting in this way, undoubtedly position homeopathic practice on the margin of mainstream medical practices. In all extracts, homeopathic practice is presented through the social actions performed, positioning homeopathy in a last-resort-form' and as a contested and contentious 'type' of practice.

8.3 The Boosting-the-credibility-of-homeopathy Strategy

In the second discursive strategy, boosting-the-credibility-of-homeopathy, the participants account for their everyday homeopathic practices through the social actions performed. In a similar way to the institutionalised context of the research interviews with practitioners in Chapter 7, the participants here, in the formal institutionalised homeopathic consultations, accomplish this in a range of ways: namely, through 'troubles telling' talk (Jefferson 1984; Jefferson and Lee 1981), or by undermining potential criticisms, or/and by deploying the (mundane) 'X' and

(extraordinary) ‘Y’ device (Jefferson 1984; Wooffitt 1992), combined with other discursive devices, such as to maximise the persuasive power of the social actions being performed (Edwards and Potter 1992).

At the same time, homeopathic practice is contingently, negotiated, produced and sustained as something potentially contested, controversial and located in a culture of scepticism. Another related feature is that homeopathy is downgraded as an alternative positioned on the margins of wider notions of mainstream medicine, which is presented as the accepted yardstick for practice. In accomplishing this, participants deploy the discursive resources made available to make their own individual practices credible while at the same time attending to and managing issues of personal accountability by constructing the facticity and normativity of their events and descriptions (Edwards and Potter 1992).

8.3.1 Undermining Potential Criticisms

This is observed throughout the succeeding extracts seen below:

Extract 8:5

1. SV: I wonder why it's based on like cures like is that just a natural
2. observation of the universe that homeopathy is based on =
3. BH: = I like to think so (.) and it was around before Hahnemann the idea
4. was of course (.) apparently Hippocrates (.) was playing around with
5. idea for a while but then he went the other way ((mainstream
6. medicine)) to what then became Hahnemann's that was my
7. understanding what was that three thousand years ago or something (.)
8. and he was thinking like cures like there's an idea (.) hmm (.) and I
9. think there is some evidence that it has been around in other
10. civilisations as well (.) maybe the Egyptian (.) there are wild
11. arguments about its origins (.) hmm it's older and more effective than
12. most people give it credit for

Extract 8:5 is taken near the end of the consultation after the homeopathic medicine has been prescribed. In this fragment of conversation, SV (the patient) is discussing with BH (the practitioner) the notion of homeopathy in relation to an apparently natural observation of the universe. As a way of describing homeopathy, BH constructs and portrays vivid and specific evidence with reference to notions of an historical context to the development of homeopathy by inferring it has longevity and a prestigious, well-established history. In so doing, SV and BH's discursive work boosts the credibility of homeopathy. It is primarily BH's strategy that works to achieve this by undermining a potential criticism: 'it's older and more effective than most people give it credit for' (Lines 11-12). The function of the strategy is to enhance the credibility of her practice. So, for both SV and BH, their co-construction attends to the credibility of their individual practices. Furthermore, by making an explicit contrast with conventional medicine, homeopathic practice becomes presented as a contested and controversial 'type' of practice—albeit with considerable benefits and as an alternative to notions of mainstream medicine.

SV's utterance is furnished with 'I wonder why it's based on like cures like is that just a natural observation of the universe that homeopathy is based on' (Lines 1-2) which is performed as a request and portrays homeopathy as constituted as natural in relation to the universe. The use of the aphorism 'like cures like' (Line 1) sets out the notion of agency when discussing homeopathy. Here, the use of 'like cures like' (Line 1) and the external referents of 'just a natural observation of the universe that homeopathy is based on' (Lines 1-2) together serve to emphasise that the event being discussed diminishes human agency, and is a way of attending to and managing the overall credibility and objectivity of the inferences made (Wooffitt 1992). The particle 'just' (Line 1) on this occasion is 'restrictive' and functions to offer an interpretation

and therefore limits the propositional meaning. In addition, the use of ‘just’ (Line 1) illustrates the un-remarkableness of homeopathy by comparing it to a commonplace notion significantly referred to as a ‘natural observation of the universe’ (Lines 1-2) and thus emphasises the normativity of it as a practice (Lee 1987; Potter 1996).

In an immediate and spontaneous response, BH treats SV’s utterance as a request. He invokes ‘I like to think so’ (Line 3), which is heard to be in alignment with the inferences made in the prior segment of talk. BH follows this with the statement ‘and it was around before Hahnemann the idea was of course (.) apparently Hippocrates (.) was playing around with idea for a while but then he went the other way ((conventional medicine)) to what then became Hahnemann’s’ (Lines 3-6) as a way to promote, boost and substantiate credible evidence in relation to the longevity and development of ideas of homeopathy. Through making relevant ‘Hahnemann’ (Lines 3 and 6) and ‘Hippocrates’ (Line 4), BH is drawing upon these resources as corroborative evidence to work up authenticity into the inferences regarding the ‘idea’ (Line 3) in order to establish the facticity of the version and thus downplay and counter the notion that the inferences made are motivated by self-interest in promoting homeopathy (Edwards and Potter 1992; Wooffitt 1992). In claiming ‘Hippocrates (.) was playing around with the idea for a while but he then went the other way ((mainstream medicine)) to what became Hahnemann’s’ (Lines 4-6), BH makes relevant that there is a contrast and distinction between homeopathy and mainstream medical practices, inferring that homeopathy has specific characteristics and features separate from notions of mainstream medicine. In this way, homeopathy is presented as an alternative to mainstream medicine and in thus positioned as a practice on the margins.

In following the data, BH's remarks are designed to be heard as an assessment: 'that was my understanding what was that three thousand years ago or something (.) and he was thinking like cures like there's an idea (.) hmm' (Lines 6-8). By describing the event as 'three thousand years ago or something', BH adopts precise numbering to portray the accuracy of a previous time period and thus adds credibility to the claim. Furthermore, to substantiate BH as reliable, competent and credible, the assessment 'he was thinking like cures like there's an idea' (Line 8) is deployed in a similar way to have the effect of the active voice. Here the formulation of another person's reaction to corroborate the description is portrayed as a thought directly reported as an explicit reference to Hippocrates (Edwards and Potter 1992; Wooffitt 1992). By claiming, 'like cures like there's an idea' (Line 8) in the voice of another, BH presents it like it was said (or in this case thought) at the time and is the way that BH talks up the initial 'discovery' of homeopathic practice—homeopathy is three thousands year old so it must be credible.

To display and establish persuasiveness in the account, BH provides further information to substantiate the authenticity value: 'and I think there is some evidence that it has been around in other civilisations as well (.) maybe the Egyptian' (Lines 8-10). At the same time, BH externalises the apparent source of homeopathy to earlier and wider cultural influences, such as 'Egyptian' (Line 10) as well as being linked to and part of the Greek civilisation by evoking Hippocrates (Line 4). Doing so makes it difficult to challenge BH because the description is produced as an assessment—'I think there...' (Lines 8-9) and 'maybe' (Line 10)—inferring that these resources are being deployed as stake inoculation to head off or minimise the potential for the claim to be discounted as the promotion of self-interest. Furthermore, on this occasion 'I think' (Lines 8-9) and 'maybe' (Line 10) are used to manage potentially awkward

issues in delicate and sensitive ways and is a way of attending to the responsibility of personal accountability and to counter any potential challenges to the claims being made (Edwards and Potter 1992; Wooffitt 1992).

BH follows this with the claim, ‘there are wild arguments about its origins’ (Lines 10-11), suggesting that the origins of homeopathy is contested, controversial and provoking potentially volatile debates. To further substantiate this, BH can be heard to undermine a potential criticism by stating, ‘it’s older and more effective than most people give it credit for’ (Lines 11-12)—suggesting that there is a sceptical counter-argument that homeopathy might not be authentic, have medicinal properties or potentially new without any historicity.

In a defence of her practice, BH is observed to be enhancing its credibility. She accomplishes this by undermining a potential criticism and at the same time boosts the credibility of homeopathy by talking it up as having a well-established history with medicinal and potential therapeutic benefits.

8.3.2 Deploying the (Mundane) ‘X’ then (Extraordinary) ‘Y’ Device

Extract 8:6

1. CO: so they are a bit like immunisations (.) these remedies except that they
2. are homeopathic and they are designed to try and teach your system (.)
3. give your system (.) a ehh (.) natural way to help sort itself out ehh (.)
4. mm if ehh um (.) er what I would do is I’d put probably ehh mm (.)
5. four and five days between each of them if there is a clear
6. improvement after any single one of them then I’d wait longer
7. DK: (.) but don’t take them together
8. CO: I wouldn’t (.) don’t take them together (.) take (.) what you want to do
9. is put the remedy in see what happens (.) if it’s working out well wait
10. beware that even if things aren’t improving (.) there will always (.)
11. probably be good days and bad days ups and downs (.) there is the
12. possibility that it will work instantly

In Extract 8:6, the action is taken near the end of the consultation, CO (the practitioner) is giving advice prior to prescribing a homeopathic medicine. Simultaneously, CO is persuasive in the way she discusses and describes the apparent medicinal nature of homeopathic remedies in relation to its potentially positive benefits. In doing so, CO justifies (homeopathic) remedies by aligning them with immunisations and notions of a natural-treatment approach as a way of boosting-the-credibility-of-homeopathy. CO's strategy is constructed in an elaborate three-part description. This is followed by CO drawing upon the formulation 'At first I thought ... (mundane) 'X', (Line 10) but then I realised...' (extraordinary) 'Y' (Line 11-12) device (Jefferson 1984; Wooffitt 1992) to promote the externality and facticity of the event. By using this formulation, CO manages to pass on potentially contentious information while attending to issues in relation to her personal accountability and the normativity of the practitioner/patient interaction. The function of the strategy is to enhance the credibility of her practice. All aspects therefore warrant the factual status of the apparent benefit of the homeopathic remedy (Wooffitt 1992).

In the first unit of talk, CO raises an issue that is portrayed as the possible source and nature of the homeopathic remedy. In doing so, CO begins to talk up the mundane properties of the homeopathic remedy (Lines 1-11), which can be heard as the introduction of the (mundane) 'X' component of the 'X then Y' device. She claims: 'so they are a bit like immunisations these remedies except that they are homeopathic' (Lines 1-2). This is a vivid description (Edward and Potter 1992), in the way that she orients and aligns homeopathic remedies with immunisations. In comparing immunisations with homeopathic remedies, CO identifies unspecific but potentially similar characteristics. This infers that homeopathic remedies are

portrayed as a credible form of medicine, albeit with potentially ‘alternative’ properties to immunisations.

In the second unit, CO goes on to provide detailed information that facilitates the notion that homeopathic remedies have intrinsic medicinal properties. She promotes the mechanism by claiming, ‘and they are designed to try and teach your system (.) give your system (.) a ehh (.) natural way to help sort itself out ehh’ (Lines 2-3), which is used to substantiate a technical mechanism of the ‘natural’ that acts on one’s system.

Here, CO’s utterance is designed in a three-part sequence. The first item in the list displays a substance with a structural influence, ‘they are designed to try and teach your system’ (Line 2), with apparently instructive properties that act on an individual’s constitution. The second item, ‘give your system’ (Line 3), emphasises the prior utterance and the intrinsic effect on one’s health status. The third item is explicit in the description of an apparently ‘(.) a ehh (.) natural way to help sort itself out ehh’ (Line 3)—a ‘natural’ (Line 3) approach to potentially curative effects. In constructing her claim in this way, CO works up the commonality and general features of the homeopathic remedy and emphasises the general character of its potential effect (Jefferson 1990). CO is thus attending to the promotion of homeopathic remedies while talking up and boosting the credibility of homeopathy.

In the third unit, CO is observed to be offering specific and detailed advice. Expressing the meticulousness of remedy-taking, she offers detailed, informed advice—‘er what I would do is I’d put probably ehh mm (.) four and five days between each of them if there is a clear improvement after any single one of them then I’d wait longer’ (Lines 4-6)—through resources that demonstrate explicit behaviour as the normative requirement in relation to gaining a potentially positive

outcome as described by a credible practitioner. This is followed by DK, who displays her affiliation to these conventions—‘but don’t take them together’ (Line 7)—with what is heard as a request to clarify the information from CO. Accordingly, CO reiterates further advice by borrowing lexical components from DK’s inference. She immediately invokes as advice-giving—‘I wouldn’t (.) don’t take them together (.) take (.) what you want to do is put the remedy in see what happens (.) if it’s working out well wait’ (Lines 8-9)—again detailing particulars with regards to the relevance of specific behaviour. CO is once more observed to be promoting the intrinsic qualities of homeopathic practice.

In describing an event as ‘it happened’, CO refers to an event as the kind of thing that ‘happens’ to people by stating, ‘put the remedy in see what happens’ (Line 9). She thus emphasises the potential medicinal properties as independent of DK’s own individual agency, action and intentions, which is a way of boosting the credibility of homeopathy. Making a further reference to the potential experience of the homeopathic remedy and subsequent appropriate action to take, ‘if it’s working out well wait’ (Line 9), CO invokes potentially positive attributes, inferring that circumstances may prevail that characterise a change. In formulating an explanation in this way, the inferences warrant the ascription of favourable attributes of homeopathy to the recipient DK.

Moreover, at this point in the interaction CO can be observed to be attending to and constructing what sounds like potential scepticism about the benefit in relation to the remedy, by displaying a potential criticism: ‘beware that even if things aren’t improving’ (Line 10). This is also a good example of the mundane ‘X’ component of the ‘X’ then (extraordinary) ‘Y’ device proposed by Wooffitt (1992), in the way that CO depicts a mundane activity to potentially play down the positive effects of the

remedy with ‘beware that even if things aren’t improving’ (Line 10) before citing the extraordinary Y.

CO continues with a note of caution set over three components: ‘there will always (.) probably be good days and bad days ups and downs’ (Lines 10-11). This is structured in a three-part list to add persuasiveness and authenticity to broad general notions in relation to taking the remedy (Jefferson 1990).

CO then invokes the (extraordinary) ‘Y’ component of the ‘X then Y’ device (Wooffitt 1992) by presenting homeopathy as having the potential for immediate medicinal effects. She advises DK that ‘there is the possibility that it will work instantly’ (Lines 11-12). The use of the resource ‘instantly’ presents the potential benefits of homeopathy as immediate and exceptional.

By deploying the various discursive devices discussed above, CO manages the boosting-the-credibility-of-homeopathy while at the same time working to present potentially contentious and controversial information as commonplace. Moreover, the construction suggests for that for CO to make homeopathic practice credible presents considerable difficulties. However, by attributing to intrinsic qualities in relation to the effect of the remedy, CO is managing her personal accountability by presenting her claims as ‘out-there’ (in the mechanism of the remedy) and not as her inner desires or beliefs.

Extract 8:7

1. DH: ((sounds like pages being turned)) the homeopathic remedy may be
2. able to stabilise that the homeopathic remedies are one hundred
3. percent safe they can’t cause you any toxicity and they can’t cause you
4. any harm
5. PP: right =
6. DH: = they (.) they are stimuli extremely fine stimuli and they are an
7. extremely low dose and they are very very (.) specific unlike orthodox
8. medicine they (.) try to control the symptom by putting quite large

9. amounts of the substance in to (PP: okay) control the symptom the
10. homeopathic approach is not to try and control but to try and
11. reprogram by putting in a very specific stimulus rather than a kind of
12. generic stimulus to control (.) so there's no danger from them they can
13. react very quickly

Extract 8:7, with DH (the practitioner) and PP (the patient), is taken near the end of the consultation prior to prescribing a homeopathic medicine. In organising his talk and subsequent strategy, DH constructs what can be heard as a conspicuous, persuasive and rational explanation of the safety and efficacy of homeopathic remedies. He goes on to contrast orthodox or conventional medicine with the homeopathic approach. In a defensive orientation of his practice, he describes the intricate process involved as a way of legitimising the described evidence as credible and factual information, with the effect of boosting the credibility of homeopathy. By accounting in this way, DH works to enhance the credibility of his practice as a reliable person doing what 'homeopathic' practitioners do: giving advice on medically related topics.

In a similar way to CO's and DK's interaction (Extract 7:6), here the explanation from DH is structured in an elaborate three-part description. First, DH describes the mechanism of the homeopathic remedy. In the second unit, there is a reference to orthodox medicine, which is used in a contrasting frame with homeopathy. This works to present the category 'homeopathy' as an alternative to notions of mainstream medicine. In the third unit, DH is observed to be reporting further effects portrayed as specific to the homeopathic approach. Within the three-part description, DH can be observed to deploy the (mundane) 'X' then (extraordinary) 'Y' device to add persuasiveness and attend to the potentially contentious claims being made. All aspects therefore warrant the factual status of the

precise and vivid details that are relevant to promoting the credibility of homeopathy—and specifically the homeopathic remedy. Further, throughout the interaction, PP's 'right' (Line 5) and 'okay' (Line 9) are heard as minimum tokens of encouragement to indicate that DH can continue to talk. In this way, PP allows DH to complete his explanations spontaneously without interruption (Wooffitt 1992).

In the first unit of the three-part sequence, DH's description is portrayed as factual information in relation to the efficacy and safeness of the apparent homeopathic remedy's action. He immediately invokes, 'the homeopathic remedy may be able to stabilise' (Lines 1-2), suggesting that the remedy has potential benefits. Moreover, in accounting this way DH is observed to be drawing upon the (mundane) 'X' component (Wooffitt 1992). In doing so, DH constructs the mundane circumstances of the event to talk up the potential positive action of the homeopathic remedy. Consequently, further into the interaction, DH is observed to be talking up the onset of the homeopathic remedy as potentially to 'react very quickly' (Line 13), invoking the (extraordinary) 'Y' component of this rhetorical structure.

DH continues with talk to promote the harmlessness of homeopathy: 'that the homeopathic remedies are one hundred percent safe they can't cause you any toxicity and they can't cause you any harm' (Lines 2-4). This claim is structured in a list format imbued with persuasive value regarding the potential benefits of homeopathy. The notion of an apparent risk-free phenomenon is set in a three-part sequence, 'one hundred percent safe they can't cause you any toxicity and they can't cause you any harm' (Lines 2-4), which warrants a general commonality to what is heard as an accurate portrayal of a risk assessment. This implies that the notion of the remedies as potentially harmless is the interactional business being performed in this situation (Jefferson 1990).

To build up further objectivity into the claim, DH invokes, again in a three-part list format, a further boost to the credibility of homeopathy—‘they (.) they are stimuli extremely fine stimuli and they are an extremely low dose and they are very very (.) specific’ (Line 7)—in order to maximise the precision and credibility of the remedies’ efficacy and subsequent precise therapeutic characteristics (Jefferson 1990). This is followed by DH illustrating the significant features of the remedy action. By claiming ‘extremely fine stimuli’ (Line 6), there is an emphasis on the dimensions of the material; by displaying ‘extremely low dose’ (Line 7), the emphasis is on the minute properties; and by claiming that the remedies are ‘very very (.) specific’ (Line 7), there is an emphasis on the accuracy of the materials’ action. In doing so, DH is drawing on the extremity of each item cited, which maximises the proportion of the apparent effect but at the same time minimises their potential harm in order to add persuasiveness to the overall argument by proposing that the phenomenon is in the object (Pomerantz 1986). More than this, DH is mobilising talk about homeopathy’s potential therapeutic benefits.

In the second unit of the elaborate three-part sequence in DH’s strategy, he constructs an explanation situated in what is heard as a contrasting frame to the prior inferences above. Next, DH references notions of mainstream medicine as the appropriate yardstick by which to measure. Through an assessment of the action of medicine, DH claims that ‘unlike orthodox medicine they (.) try to control the symptom by putting quite large amounts of the substance in to control the symptom’ (Lines 7-9). This implies that the characteristics of orthodox medicine are directly opposed to the notion of the homeopathic remedies, and reflects the prevailing notions of the mechanism of mainstream medicines.

In the third unit in the sequence, DH reiterates the notion of the accuracy of the homeopathic remedy in contrast to the apparent generality of mainstream medicine. He makes relevant that ‘the homeopathic approach is not to try and control but to try and reprogram’ (Lines 9-11), inferring that the two modes of action have contrasting mechanisms. By attributing the notion of ‘reprogram’ (Line 11) to the homeopathic remedy, DH offers an inference that serves to work up a technical portrayal of the phenomenon. DH goes on to provide more information to substantiate and justify the authenticity of the inferences, invoking ‘by putting in a very specific stimulus rather than a kind of generic stimulus to control’ (Lines 11-12), which works to bolster the credibility of homeopathy. This is heard as a reference to a particular action, ‘putting in’ (Line 11), as a way of qualifying the prior claim. By making relevant an explicit contrast, ‘a very specific stimulus rather than a kind of generic stimulus to control’ (Lines 11-12), DH again refers to the precision of the homeopathic remedy in contrast to orthodox medical approaches.

This is substantiated immediately when DH defends homeopathy by claiming, ‘so there’s no danger from them’ (Line 12), which is designed to counter the likelihood of a critical, sceptical or negative attribute being drawn from the claims being made and is how DH attends to his accountability in terms of the claims being made. DH follows this immediately by making explicit, ‘they can react very quickly’. This claim is observed as the (extraordinary) ‘Y’ component, which works to greatly bolster the prompt and precise mechanisms of homeopathic remedies. The reaction is emphasised as ‘very quickly’ (Line 12), which implies that this mode of action is potentially the exceptional activity of the homeopathic remedy.

Through his account and over complex discursive structures, DH talks up homeopathy by constituting the potentially therapeutic benefits of the remedy while at

the same time minimising his individual involvement and thus diminishing his personal agency. In portraying objective and factual evidence in this way, DH is observed to be drawing on various discursive devices to enhance the credibility of his practice. At the same time DH's strategy works to boost the credibility of homeopathy by deploying the (mundane) 'X' then (extraordinary) 'Y' discursive device (Wooffitt 1992) in a contrast structure to notions of mainstream medicine.

8.3.3 Summary of the Analysis in Extracts 8:5-8:7

In the above strategy, boosting-the-credibility-of-homeopathy, the function is to enhance the credibility of the participants' practices. Extracts 8:5-8:7 demonstrate the ways in which the interviewees deploy the discursive resources made available to emphasise the potential benefits of their contingently formulated homeopathic practices. This is achieved in a range of ways illustrated above, combined with various discursive devices to maximise the persuasive power of the inferences made. In Extract 8:5, SV and BH undermine potential criticisms of homeopathy to enhance its credibility as a well-established form of treatment and by citing a credible history.

Significantly, CO (Extract 8:6) and DH (Extract 8:7) work to boost the credibility of homeopathy by providing empirical evidence with a before/after formulation. These practitioners are not people who are promoting contentious or controversial information; rather, they are reasonable, neutral, competent observers of homeopathic practice who are merely passing on the usualness of facts as they are.

In other words, they are building up their personal credibility as reliable speakers and as credible practitioners attending to the normativity of what practitioners do: give advice and display knowledge in the context of the homeopathic

consultation. However, the downside of presenting homeopathy as a contested and controversial knowledge claim is to locate it on the margins of mainstream medical practice. This is the way in which homeopathic practice is negotiated, (re)-produced and sustained on the margins.

8.4 Managing-homeopathy-as-alternative Strategy

There is also a third way in which the participants' accounts worked to present homeopathic practice as positioned on the margin from mainstream acceptance, this is identified through the managing-homeopathy-as-alternative strategy.

In examining this discursive strategy, I illustrate the ways in which the interviewees construct and introduce personal factors that offer homeopathy as a problematic, potentially out-of-the-ordinary, alternative 'type' of practice and account for their individual use of it. Similarly, the interviewees during the research interview in Chapter 7, were also observed to orient to this strategy. Here, in the more formal, institutionalised setting of the consultative process, participants orient to this strategy through their contingently formulated co-constructions. In doing so, homeopathy is presented as being positioned on the fringes of mainstream medical practices. Again, the participants' strategies function to enhance the credibility of their practice through the deployment of specific social actions to accomplish the business at hand. At the same time, they attend to and manage issues in relation to personal accountability, thus illustrating the difficulties involved in making homeopathy credible.

8.4.1 Talk About the Alternative

This is observed throughout the defence-oriented talk to make their practices credible, seen below:

Extract 8:8

1. BH: okay (.) do you know anything about homeopathy
2. SV: no not really much at all ehh (.) I know a (.) little bit about alternatives
3. because I read it for instance unfortunately our pharmacology text
4. book says what's his name Hahnem or =
5. BH: = Hahnemann =
6. SV: = Hahnemann (.) it says they were speaking about the history of ehh
7. (.) pharmacology and how it got started in the introduction of my book
8. they sort of say well depending on the reaction to things like
9. ((inaudible)) and mercury (.) and all of these more hard ehh (.) core
10. practices that different doctors (.) had been using (.) Hahnemann came
11. along and said homeopathy actually if you use a little bit it can work (.)
12. that got me interested (.) then the text went on to sort of go but y'know
13. (.) he's not for real and we're for real (.) and we'll get on with it sort of
14. thing so that's ehh

In Extract 8:8, the segment of talk between BH (the practitioner) and SV (the patient) is taken from the beginning of the consultation as part of the introductory sequence. The function of the strategy is to enhance the credibility of their practices. The participants are talking about the contents of a pharmacology book. SV assumes the rhetorical business of talking about homeopathy as an alternative type practice and as something contested and controversial presented in a culture of scepticism. By building their descriptions as factual and as an accurate set of events, the participants attend to and manage issues in relation to personal accountability to counter any potential challenges to credibility concerning the claims made. This is accomplished by constructing an illustrated reference to a 'pharmacology textbook' (Lines 3-4), which is presented as a standard piece to highlight the differences between medical

practices and homeopathy. In doing so, SV portrays the medical practices of doctors as potentially archaic in contrast to an apparently small amount of homeopathic material that is described as a credible treatment option.

SV makes an explicit criticism in relation to Hahnemann as potentially discreditable—claiming ‘he’s not for real’ (Line 13)—and demonstrates homeopathy as a contentious and controversial practice—‘he’s not for real and we’re for real’ (Line 13)—in contrast to mainstream medical practices. Notably, SV attributes the out-of-the-ordinary homeopathic method—‘Hahnemann came along and said homeopathy actually if you use a little bit it can work that got me interested’ (Lines 10-12)—as a personal factor that is attributed to her interest in looking to homeopathy.

BH’s utterance, ‘okay (.) do you know anything about homeopathy’ (Line 1), is designed to elicit an explicit response from SV in relation to a cognitive assessment concerning knowledge of homeopathy. Accordingly, SV responds and displays a segment of talk suggesting that she had no prior knowledge of homeopathy by stating ‘no not really much at all ehh’ (Line 2) as an immediate and spontaneous response in alignment with BH’s request. Further, SV’s description is worked up in this way to portray that she has little homeopathic knowledge. This can be heard as a way of attending to her responsibility to her own personal accountability as a credible speaker and as an ‘inoculation’ to head off or minimise any potential challenge that SV is promoting or displaying bias towards promoting homeopathy in her following descriptions (Potter 1996).

SV immediately follows this with the an assessment, ‘I know a (.) little bit about alternatives’ (Line 2), which is portrayed in such a way as to provide an understanding that categorises homeopathy as analogous with ‘alternatives’ (Line 2).

In making this explicit comparison with ‘alternatives’ (Line 2) relevant, SV begins to introduce empirical evidence to support and establish homeopathy organised in this way. Immediately, SV goes on to build up what is heard as an accurate, credible and factual representation of a reported passage taken from her pharmacology book: ‘because I read it for instance unfortunately our pharmacology textbook says what’s his name Hahnem...’ (Lines 3-4). This serves to portray the textbook as reliable and corroborative evidence of the claims that she makes (Horton-Salway 2001). At the same time, SV’s utterance is designed to be heard as a request to invite BH to fill in the reference to the apparent ambiguity surrounding the name ‘Hahnem’ (Line 4).

BH responds immediately by completing SV’s preceding utterance with ‘Hahnemann’ (Line 5), to confirm the name of the physician, which demonstrates affiliation with the inferences made by SV and demonstrates her knowledge of the topic of homeopathy. SV continues to talk up the facticity of her account with further illustrations, apparently from the pharmacology book: ‘it says they were speaking about the history of ehh (.) pharmacology and how it got started in the introduction of my book they sort of say’ (Lines 6-8). This is referenced as a direct source as part of the consensus about and corroboration of claims that follow.

Formulating events in this way portrays an experience independent of the speaker’s agency, which adds to the overall credibility of the account (Wooffitt 1992). Furthermore, by stating ‘our pharmacology textbook says’ (Lines 3-4), ‘it says’ (Line 6), ‘they were speaking about...’ (Line 6), and ‘they sort of say’ (Line 8), SV is observed to be doing a shift in footing that assists in building up the persuasive characteristics and attending to the factuality of the construction. Here, SV is presenting as a neutral, competent observer/speaker, merely passing on the views represented as being drawn from an original pharmacology book. In so doing, SV,

through her formulation, gives the appearance of neutrality as a way of attending to and managing personal accountability. At the same time, SV engages in managing the facticity, objectivity and persuasiveness of the inferences being made (Goffman 1981).

To build up further reliability for the mechanism of homeopathy, SV makes an explicit contrast and criticism in relation to the potentially detrimental mainstream medical practices—‘they sort of say well depending on the reaction to things like ((inaudible)) and mercury (.) and all of these more hard ehh (.) core practices that different doctors (.) had been using (.) Hahnemann came along and said homeopathy actually if you use a little bit it can work’ (Lines 8-11)—as a way to bolster the credibility of favourable homeopathy in a context when mainstream medicine is apparently accountable for ‘hard ehh (.) core practices’ (Lines 9-10). This suggests that under the circumstances described, homeopathy offered a progressive solution as a minute material with medicinal properties. This is followed immediately with SV introducing the homeopathic approach as something that apparently uses a small dose to be effective, and as factual evidence from the voice of Hahnemann himself, presented as if it were said exactly like that at the time: ‘Hahnemann came along and said homeopathy actually if you use a little bit it can work’ (Lines 10-11). This permits SV to display the reported dialogue to substantiate her claim and to build up both reliability and credibility. This functions in a similar way to the ‘active voice’ by adding objectivity into the claim being made and thus making it hard to construct a counter-challenge (Wooffitt 1992). SV goes on to display what is heard as a result of reading the passage, ‘that got me interested’ (Line 12), which is presented as an assessment to suggest that the information described above was a significant personal factor in relation to looking to homeopathy.

SV furnishes her account further with potentially negative attributions that are depicted in an argumentative sequence—‘then the text went on to sort of go but y’know (.) he’s not for real and we’re for real (.) and we’ll get on with it sort of thing so that’s ehh’ (Lines 12-14)—that functions as a potential criticism of Hahnemannian (homeopathy) practices. This suggests that both homeopathy and Hahnemann have a contested, controversial and sceptical property for the hypothetical authors of the text. In working up the persuasiveness of the claim, SV adopts active voicing, demonstrating that the inferences made are objective to other people who read the text. The critical and sceptical claim, ‘he’s not for real’ (Line 13), presents Hahnemann as discreditable when contrasted with conventional pharmacology. By reporting in this way, the inferences carry a persuasive value, because they are portrayed as accurate—how the words were presented in the text. SV thus makes a strong case, which implies facticity and authenticity concerning the claims being made (Wooffitt 1992). So SV is observed to be orienting to homeopathy as a contested and controversial, out-of-the-ordinary, alternative ‘type’ of practice when contrasted with notions of mainstream medicine.

Extract 8:9

1. DK: I think in nineteen ninety-five (.) I took a few homeopathic remedies
2. but that was because I was in the UK for the first time and I was
3. staying here in Glasgow and well I was in London and in Edinburgh
4. there was a Boots and I saw alternative medicine (.) them in there and I
5. think they were affordable and they came with a free booklet
6. CO: yeah =
7. DK: = and they were my only experience with them until the bottle ran out
8. CO: okay mhm did you get cured
9. DK: well (.) they were very very helpful (.) I didn’t really know what I
10. was doing (.) so I took pills for a while rather than practicing
11. homeopathy I took them together with ordinary medicine

The final Extract (8:9) is taken near the end of the consultation with DK (the patient) and CO (the practitioner). DK is referring to a prior event in which she describes taking homeopathic remedies. The strategy is furnished further with DK making relevant an apparent first-time experience, which is scripted to portray a solid factual tone to her story regarding taking homeopathic remedies. The function of the strategy is to enhance the credibility of her practice. In so doing, DK introduces personal factors for her individual use of homeopathy, stating ‘I saw alternative medicine (.) them in there and I think they were affordable and they came with a free booklet’ (Lines 4-5). By accounting in this way, DK constructs and talks about homeopathy as a potentially contested, controversial, out-of-the-ordinary and alternative ‘type’ of practice.

At the beginning of her account, DK is observed to be vividly describing a point in time when she took homeopathic remedies—‘I think in nineteen ninety-five (.) I took a few homeopathic remedies’ (Line 1)—as an accurate assessment of when she first experienced homeopathy. Moreover, she is making an explicit reference to confirm the objectivity and accuracy of the event. However, by invoking ‘I think’ (Line 1) as an assessment, the features observable indicate that DK is working to counter any potential challenge to the specific accuracy of the apparent claims (Potter 1996) and is DK’s way of beginning to manage responsibility for her personal accountability.

DK follows this immediately with what is heard as a potential justification. This is done by introducing personal factors related to looking to homeopathy: ‘but that was because I was in the UK for the first time’ (Line 2). This reference to a specific setting and time orientation serves to portray an accurate everyday and routine event. Immediately following this, a further segment of talk is invoked to

substantiate and legitimise the chronology of an apparent discovery: ‘and I was staying here in Glasgow and well I was in London and in Edinburgh there was a Boots and I saw alternative medicine (.) them in there’ (Lines 3-4). This is designed to align homeopathic remedies explicitly with the category distinction of alternative medicine found at a Boots store in Edinburgh. By claiming ‘I saw alternative medicine (.) them in there’ (Line 4), DK is portrayed as a neutral, competent observer—merely a witness to the ‘alternative medicine’ (Line 4) in Boots—and thus DK is independent of her own individual agency, action and intentions, with no stake in promoting homeopathy—any neutral competent observer would also have this available to them if in a similar situation. Moreover, making Boots relevant, the most mainstream and long established high street chemist, offers further neutrality of her observer status. Also by explicitly referring to ‘alternative medicine’ (Line 4), DK positions homeopathy as analogous to the ‘alternative medicine’ (Line 4) categorisation. Furthermore, this suggests that there is a kind of medicine that *is* mainstream, and homeopathy is potentially and apparently *not*.

DK goes on to build up a further three-part sequence to provide personal factors for looking to homeopathy. The inferences portray further instances of the character and features of her experience in relation to ‘alternative medicine’ (Line 4). The first item on the list is constructed as a claim to a monetary evaluation—‘and I think they were affordable’ (Lines 4-5)—and is designed to be displayed as a potentially positive attribute. This is followed immediately by ‘and they came with a free booklet’ (Line 5), which characterises the experience as something available by using a type of brochure. The third item on the list, ‘and they were my only experience with them until the bottle ran out’ (Line 7), is a justification to looking to homeopathy by inferring that it was a one-off event and is at the same time presented

as a formulation that provides the basis to emphasise the notion of her experience as a factual event. In doing so, DK, through the sensitive mobilisation of her talk, justifies her practice in looking to homeopathic treatment.

This is followed by the practitioner's shift back to the task-related normative activity of uttering what is heard as a request. CO states 'okay mhm did you get cured' (Line 8), which is explicitly relevant to eliciting a response from DK regarding potential medicinal effects. Accordingly, DK responds immediately and spontaneously with 'well (.) they were very very helpful' (Line 9), which is heard as a potentially positive attribute in relation to the notion of problem solving, and at the same time is used to bolster the credibility of homeopathy. By claiming 'very very helpful' (Line 9), DK is observed to be legitimising the claim of the curative properties of the 'alternative medicine' (Line 4) by reporting the phenomenon as existing in the object. The effect is to add persuasiveness to the inferences made.

DK follows this immediately with an evaluation. In a three-part list DK displays a cognitive assessment—'I didn't really know what I was doing (.) so I took pills for a while rather than practicing homeopathy I took them together with ordinary medicine' (Lines 9-11)—inferring a lack of knowledge in relation to her management of talk about homeopathy as a treatment. First, by revealing an apparent lack of knowledge, DK emphasises a potential problem concerned with taking homeopathy effectively. DK claims 'I didn't really know what I was doing' (Lines 9-10), which is presented to demonstrate a potentially problematic, ambiguous notion in relation to taking homeopathy. Second, DK's claim, 'so I took pills for a while rather than practicing homeopathy' (Lines 10-11), displays the behaviour of taking pills, thereby suggesting that homeopathy is a practice apparently beyond merely taking pills. Moreover, DK misaligns committing herself to making a claim for the therapeutic

benefits of homeopathy. This infers that DK has a potential claim that homeopathy did not have medicinal effects. Third, by making relevant ‘I took them together with ordinary medicine’ (Line 11), DK avoids making an explicit response in relation to CO’s request. DK again portrays non-committal features and plays down the potential medicinal effects of homeopathy on its own, by claiming to take homeopathy together with conventional medicine. By making ordinary medicine relevant, DK confirms that homeopathy is viewed as perhaps ‘not ordinary’, inferring that homeopathy is ‘out-of-the-ordinary, on the fringe, and an alternative on this basis when in a contrasting homeopathy/medicine structure.

8.4.2 Summary of the Analysis in Extracts 8:8-8:9

In the above extracts I illustrate the ways in which the participants, through their social actions, introduce personal factors that offer homeopathic practice as a problematic, out-of-the-ordinary, alternative ‘type’ of practice. At the same time, the interviewees account for their individual use of it. By presenting homeopathy as an explicit alternative on the fringe, there are undoubtedly significant implications in that the wider effect is to potentially and continually marginalise homeopathic practice if one links the interviewees talk to the broader ‘top-down’ informed contexts. Hence, from a ‘top down’ perspective, the hegemony of mainstream medicine is partially challenged by a potentially subordinate or marginal perspective: homeopathic practices. Therefore, a socio-political cultural struggle emerges and is vividly reproduced, negotiated and sustained in talk about homeopathy as the alternative on the margin of mainstream medical practices.

8.5 Discussion

The analyses detailed above are specific to the more formal ‘institutionalised setting’ of the homeopathic consultation and in relation to the contested and controversial topic homeopathic practices. Nevertheless, the practitioners orient to particular institutional restrictions by showing affiliation to patients whose experiences are central to the consultative process.

A further point to note is that not all the data collected from the separate consultations was included in the final analysis. The rationale being, discourse data tends to be rich therefore a particular discursive feature is identified to justify the broader argument. Essentially, the goal of analysis is to describe the organised trajectory of language use over broad strategies. It is for this reason I place emphasis on the examination of interactional strategies in contrast to a detailed analysis of the sequential context made available during the individual consultations in which they occurred.

Moreover, if all data examples were included and referenced to a even larger corpus of material the practicalities and organisation of such a quantity, would potentially make defining the analytical claims overly problematic.

What is significant is the status of homeopathic knowledge, which is an accountable issue for all the participants, especially for practitioners whose practice is congruent to more theoretical distinctions. In so doing, attending to personal accountability concerning the attributional issues of responsibility becomes a central focus for the speakers’ constructions of their practice. The analysis goes some way to support this claim and demonstrates how the function of their explanations is a discursive accomplishment to enhance their personal credibility. On this basis, their credibility as competent practitioners and patients is an issue at stake. In constructing

their talk, patients oriented to the need to show their problems were worthy of the practitioners' attention. Thus, these patients oriented to institutional norms and expectations between the practitioner/patient interactions.

Moreover, in the approach presented here it is possible to observe how the participants co-constructed and negotiated their everyday practices in the context of the 'homeopathic' consultation. In doing so, the participants' 'institutional talk' is 'naturally occurring' and uninterrupted by the presence of the researcher (Potter and Hepburn 2007). In and through the above interactive sequences, how the participants responded to and constructed their accounts depended on the contingency of the immediate situation. As anticipated, all the participants displayed variation over the course of their own talk, discourse and individual versions.

In the context of accounting for their everyday practices and as a way of enhancing personal credibility, the participants' constructions can be viewed in the broader context, which is set against notions of mainstream medicine as the taken-for-granted yardstick for practice. The analysis presented here elucidates how, in the participants' responses to their homeopathic practices, mainstream medicine goes largely uncontested as the participants reassess, establish and negotiate their talk in relation to this as a dominant organising principle, undoubtedly a mutually intelligible available social resource to all the participants and within the proposed analytical scheme outlined above.

The delicate discursive activities are made under circumstances directly encountered from past historical practices and in a genealogical context, presented over three discursive strategies. This serves to underpin the participants as attentive when they account for their everyday homeopathic practices in their co-constructed responses made during the consultative process. The broader interpretative resources

for these participants are in general the members' methods for situated sense-making. This discursive patterning is substantiated by comparing the findings with talk and accounts made relevant in the research interview context. Here, three similar strategies were deployed to manage the participants' intersubjective events when talking about the contested, controversial properties of their homeopathic practices.

In the first discursive strategy identified above, criticisms-of-medicine-to-justify-homeopathy, homeopathic practice becomes presented in a defence of their practices as an alternative in contrast to mainstream medicine. Here, the participants are observed to orient to homeopathy after apparent criticisms and failures in relation to mainstream medical practices. To a certain extent these accounts rely on a range of methods that the participants deploy—that is, by using 'troubles telling' (Jefferson 1984a; Jefferson and Lee 1992), and by building-up potential criticisms, combined with various discursive devices designed to maximise the persuasive power of their potentially factual descriptions (Edwards and Potter 1992).

In presenting their troubles, patients orient to the need to show that their troubles warrant medical or expert attention. Furthermore, they orient to the normative patient role, in which the patient is not solely responsible for their trouble—hence the externalising of experiences, events and accountable responsibilities. Moreover, the analysis shows that an activity-oriented approach offers the potential problematic situation described by the patient to be treated as relevant in the way they justify their orientation to homeopathic treatment. Thus the finding. 'Criticisms-of-medicine-to-justify-homeopathy' provides one possible way of accounting constrained within institutional talk as important for the participants themselves.

In the second strategy, boosting-the-credibility-of-homeopathy, homeopathic practice becomes presented in a defensive orientation of practice, as something that is

out-of-the-ordinary and in contrast to notions of conventional medicine, combined with various discursive devices to add persuasiveness, facticity and authenticity to the actions being made (Edwards and Potter 1992). The range of methods that the interviewees deploy include using the 'X then Y' device (Jefferson 1984; Wooffitt 1992), through 'troubles telling' (Jefferson 1984a; Jefferson and Lee 1981), or by undermining potential criticisms (again combined with various discursive devices (Edwards and Potter 1992).

Participants talk about homeopathy in ways that are similar to those in which other people talk about their life troubles or paranormal experiences (Wooffitt 1992). This informs how difficult it is for individuals to make their homeopathic practices credible. By serving homeopathic practice as a potential counter-culture to the hegemonic discourse around mainstream medicine, the strategy may serve to disempower and undermine the participants by positioning homeopathic practice in a culture of scepticism.

These participants sustain this type of marginal homeopathic practice by recurrently drawing upon a medical/homeopathic practice dyad presented in a comparative frame. In deploying this framework, the participants then use it to justify, argue for and legitimise mainstream medicine as the taken-for-granted, accepted yardstick for practice in everyday settings when accounting for homeopathic practice. This links to the broader social notions of what is inferred and culturally accepted practice by making references to mainstream medicine.

In the third strategy, managing-homeopathy-as-alternative, homeopathy becomes presented in a defensive orientation of practice and as practice that is contested, controversial, problematic and out-of-the-ordinary. The participants introduce personal factors that offer homeopathy as a downgraded alternative 'type'

of practice and that account for their individual use of it. The range of methods that the interviewees deploy include using ‘troubles telling’ talk (Jefferson 1984a; Jefferson and Lee 1981) and contrasting homeopathy consistently with mainstream medical practices, combined with specific discursive devices to talk up the persuasiveness value of the facticity and apparent authenticity of the actions being performed (Edwards and Potter 1992). The participants are explicit in the way they legitimise homeopathy as an explicit alternative to the mainstream medical practices that remains unchallenged as the dominant socio-political arena within which to evaluate practice.

Presenting homeopathy through criticisms-of-medicine-to-justify-homeopathy, boosting-the-credibility-of-homeopathy, or managing-homeopathic-practice-as-alternative’ emphasises the difficulties in making homeopathy credible and thus provides an activity-based view of the differences spelled out in the respective strategies aimed at achieving specific accounting outcomes.

This sheds light on the marginalisation questions: ‘Why this utterance here?’ ‘What is acceptable?’ ‘What are not acceptable practices?’ When seen in an institutional context of organising everyday medical practices, the design privileges one form of discourse over another to provide a dominant image. Hence, from the ‘top-down’ perspective, the Foucauldian (1980) notion of marginalisation provides a framework for the wider scepticism about the validity of homeopathic practice. Marginalisation is present when a dominant majority is at the centre of the legitimisation of the institution (mainstream medical practice with diverse marginalised practices represented at the periphery—homeopathic practice as an ‘alternative’ ‘type’ of practice). The boundaries of the institution are defined by

‘acceptable practices’ which are negotiated, resisted and made relevant by the members’ methods of sense-making.

The notion of what is an acceptable, taken-for-granted or normative practice is socially constructed and constituted over multiple discourses. In other words, through their talk, participants rely on culturally shared meanings and expectations when (re-)producing intelligible accounting practices and actions. In so doing, the effect of marginalisation varies between interactional contexts and settings. The findings show that the development configuring and sustaining medical discourse as a dominant truth claim/scientific knowledge/metanarrative is a socio-political, historically informed production and not solely a socially neutral phenomenon.

What is shown here is how, through dynamic, flexible use of the discursive interpretative resources, the participants frame everyday homeopathic practices, which are designed to perform specific social actions. The personal standpoints taken are constructed from pre-existing discursive resources that are available, made relevant and reworked to produce specific rhetorical functions, which are wholly dependent on the immediate situated business at hand (Edwards and Potter 1992; Wetherell 1998; Wooffitt 1992). The function of the strategies is to build up individual credibility. However, in the way that they frame their accounts—by contrasting homeopathy with notions of mainstream medicine—the participants are observed to unwittingly perpetuate ready-made or socio-political and historically given inequalities that are manipulated and exploited to potentially and continually marginalise homeopathy in a culture of scepticism outside mainstream acceptance

Chapter 9

Discussion

In this chapter, my intention is to revisit the context debate and argue how, at a variety of levels, it affects what participants said across the three data sets. Second, I will outline the role of the four discursive strategies identified in analytical chapters 6, 7 and 8—alignment-with-medicine, boosting-the-credibility-of-homeopathy, criticisms-of-medicine-to-justify-homeopathy, and managing-homeopathy-as-alternative—and how they work to build up credibility and locate homeopathy on the margins of mainstream acceptance. In doing so, I will draw comparisons from previous studies with reference to the literature cited in Chapter 2. Third, I will apply criteria for evaluating discourse analytical work, followed by a brief outline of the main analytical points of the study.

9.1 Referring to Context in Interaction

I showed through the analysis that it is not sufficient just to demonstrate that the description is relevant to the interaction; rather, how does talk, in a homeopathic consultation, in contrast to research interviews, account for its shape, content and character? Furthermore, what are the fundamental discursive devices of each interaction doing? In the consultative process, the participants' talk is viewed as 'naturally occurring', in that it is uninterrupted by the researcher—as opposed to more

formal institutional settings (Drew and Heritage 1992; 1992a; Hutchby and Wooffitt 1998; Potter and Hepburn 2007).

From this perspective, the research materials are viewed as closer to the notion of ‘naturalistic’; that is, the consultations or homeopathic encounter would still be ‘done’ irrespective of the researchers activities (Potter and Hepburn 2007). Note also that the context of such interaction must be examined to see how it is co-constructed by each speaker to maintain the setting, which is continually constructed in talk and throughout accounts.

9.1.1 The ‘Bottom-up’ Situated Context

From a ‘bottom-up’ perspective, I tried to show through the analytical procedures that it is not sufficient just to demonstrate that the description is an accurate depiction of the self, event or experience; rather, the utterance and subsequent description is relevant to the interactional account as part of an action orientation sequence.

During the analysis, I asked: ‘how does talk, in a homeopathic consultation, in contrast to the institutionally constrained research interview, account for its shape, content, and character?’ In both contexts, the participants’ communicative competencies were explored as sites of mutually intelligible interpersonal activities. In doing so, and by applying the DAM (discursive action model), these participants’ reflexive discursive practices and constructions were viewed as the analytical phenomena in its own right. To make their practices credible, I identified three main factors of their talk that make this happen: action—what participants are ‘doing’ with their talk; fact; interest—what discursive resources and devices participants

spontaneously invoke and use to make their talk seem persuasive, authentic, factual, and not motivated by self-interest (the way participants attend to issues of agency when making claims and manage the responsibility of personal accountability for what they have said). For these participants, their situated sense-making practices are heard as contingently formulated social events designed for specific attributional business to make their practices credible when treating homeopathic practice as a contested, controversial knowledge claim.

Note also that the context of such interaction must be examined to see how it is co-constructed by each speaker to maintain the setting, which is continually constructed in talk and throughout accounts. Therefore, what counts as relevant context and sense-meaning/relation includes drawing from the communicative competencies of producing mutually intelligible culturally available interactional understandings informed by an ethnomethodology/CA (conversation analysis), combined with a poststructuralist perspective, where there is no exactly defined line where talk stops and discourse begins. Accordingly, this study is informed by particular aspects from both ‘bottom-up’ and a ‘top-down’ perspectives.

Moreover, this notion is salient, because the categories ‘homeopathy’ and ‘mainstream medicine’ both depend on their classification as objects that are both socio-politically and historically situated and thus contingently formulated as a participants’ situated orientation. Accounting for their everyday homeopathic practices, and as a way of enhancing personal credibility, the participants’ constructions can be viewed in the broader social context, which is set against notions of mainstream medicine as the taken-for-granted yardstick for practice. Thus, presenting homeopathic practice located in a culture of scepticism on the fringe of mainstream medicine practices serves to account for the ‘political’ development of

talk and sense-making practices from a fringe group taking on board the and making use of the commonsense commonplace notion of alternative homeopathy as a contested and controversial knowledge claim and form of practice.

9.1.2 The ‘Top-down’ Post-structuralist Context

Moreover, I demonstrated that all discursive implications have the potential to be investigated in terms of grounding them in a broader ‘top-down’ socio-political, historical and cultural environment. Therefore, context from the broad perspective of the discourse has a concern for notions of power and inequalities, for the right to judge, centred on discourse as a system of representation. Utilising this premise, the analysis investigated the wider processes in play through societal contexts. In doing so, I aimed to uncover the object ‘homeopathy’ through the discourse and discursive strategy—which is defined by the processes and through an articulation of history, resulting in the history of the present (Foucault 1980). In other words, constructions of homeopathy are drawn from interpretative repertoires that are representations of the immediate past.

One can see how talk about homeopathy is inextricably linked with issues of personal credibility at the ‘bottom-up’ level and how the discursive practices and patterns engage with a wider understanding of the cultural and interpretative framework within which homeopathy finds itself on the margins of mainstream medical practice.

As observed in analytical chapters 6,7 and 8, the effect of marginalisation in discourse varies between interactional contexts and settings. In doing so, the findings show the development that configures and sustains medical discourse as a socio-

political, historically informed production and not solely as a socially neutral phenomenon. Throughout the participants' talk, the discourse is presented over broader strategies that rely on socio-political, historically formed, intelligible, culturally shared meanings and expectations when (re)-producing intelligible accounting practices and actions. In so doing, homeopathic practice is continually produced, negotiated and sustained as a diverse marginalised 'alternative' form of practice represented at the periphery of mainstream medical practice.

This notion is observed over the three data sets in chapters 6,7 and 8. The analytical findings are arranged in terms of discursive strategies—namely, alignment-with-medicine, boosting-the-credibility-of-homeopathy, criticisms-of-medicine-to-justify-homeopathy, and managing-homeopathy-as-alternative, further discussed below.

9.2 Discursive Strategies to Potentially and Continually Marginalise Homeopathy in Terms of Mainstream Acceptance

I began this study by describing how homeopathy was a derivative of mainstream medicine, and followed this by defining the distinctive elements of the homeopathic approach. I tried to make the point that, within traditional research, descriptions of homeopathy found here would be accepted as evidence of representations underlying entities. In a contrasting role, and in line with a body previous discursively informed studies by Horton-Salway (2001), Kurz *et al* (2005), Wetherell (1998), and Wooffitt (1992), the participants' talk in this present study is designed to perform specific social actions that work to enhance the credibility of their practices, and how utterances are intersubjectively being understood and

mobilised to perform further actions. In addition, in the contested and controversial topics of ME or CFS, these studies have shown how people can portray and construct their illness narrative as attributed to something physical (Horton-Salway 2001). Other participants in the interactive organisation of their talk attempt to portray the normality and ordinariness of experiencing supernatural phenomena (Wooffitt 1992). Another study (Kurz *et al* 2005) discusses how people use talk to account for and manage environmentally sustainable practices to legitimise and justify their existing patterns of behaviour, through broader discursive strategies.

It is important to acknowledge that I make no judgement about whether the claims made in this present study regarding homeopathic practice or prior DA-led approaches are representations of truth. The focus of DA demonstrates how people construct social realities through talk, showing that claims are never to be taken as just obviously, objectively, (un)-constructedly true representations of events (Edwards and Potter 1992; Wetherell 1998). Hence, I argue that an innovative DA framework is a particularly useful perspective from which to challenge taken-for-granted constructions that appear to have potentially problematic effects for homeopathic practice, organised within made-available broader interpretative resources (Horton-Salway 2001; Kurz *et al* 2005; Wooffitt 1992).

Moreover, constructions of homeopathy are treated as discursive actions drawn from various verbal contexts that are grounded in action-oriented accounts. Consequently, the ways of accounting made available to the participants are directly encountered and drawn from socio-political informed discursive history and mutually intelligible, culturally shared resources. None of the notions identified in the analysis are viewed as fixed entities; rather, they are constructed, constituted and situated in

the settings of the research interview and homeopathic consultation, dependent upon the interactional business at hand (Wetherell 1998).

Accordingly, the analysis of talk about homeopathy highlights some important differences in the way that homeopathy as a discursive resource is represented and constructed in specific settings. The participants used a range of discursive devices to make sense of their positions in relation to homeopathy. Throughout the corpus, participants' tacit understandings are identified in the ways they evaluate all their homeopathic practices in contrast to mainstream medicine, by drawing upon dichotomised categories combined with various discursive devices. In doing so, I identify discursive patterns, terms and collective sense-making orientations in relation to homeopathy, such as homeopathy and mainstream medicine categorisations, and how these are positioned in contrasting binary opposition formulations.

9.2.1 Strategies Mobilised Across the Analytical Chapters

Practitioners in Chapter 6 and patients in Chapter 7 were asked a range of questions about their individual homeopathic practices. In Chapter 6, two discursive strategies were identified in the practitioners' responses: alignment-with-medicine and boosting-the-credibility-of-homeopathy strategies. At the same time, patients also deployed two discursive strategies: the criticisms-of-medicine-to-justify-homeopathy and managing-homeopathy-as-alternative strategies. This suggests that the unique discourses made available to each data set are viewed as viable ways of speaking about homeopathy that cohere to construct the object that they orient to. Significantly, the resources available to both practitioners and patients inform the different ways they understand, experience and respond to homeopathic practice. The findings show

that the contested and challenged discourses are not omnipotent across data sets, suggesting that the social context and social relations within which the dominance and power of a discourse, discursive constraints, and availability of expert knowledge of a topic occur are not freely given. There is evidence that discourses of homeopathy operate to produce a particular ‘truth’ that seeks to invalidate potential counter-productions that dichotomise homeopathic practice as a discredited practice when contrasted with mainstream medicine.

Finally, in Chapter 8, the data source avoids active researcher involvement as it is drawn from homeopathic consultations between practitioners and their patients. In their responses, I identify three broad discursive strategies: the criticisms-of-medicine-to-justify-homeopathy, boosting-the-credibility-of-homeopathy, and managing-homeopathy-as-alternative, which can be read as part of a normative strategy for producing historically specific, acceptable and appropriate homeopathic practices made available to the entire participating homeopathic community. It is important to know that the homeopathic consultation provided quite different data in comparison to the research interviews—that is, naturally occurring data recorded between the practitioner and their patients in the homeopathic consultation, contrasted with data recorded from short semi-structured discussions arranged between the researcher and interviewees (Potter and Hepburn 2007).

It is worth noting, in the same way as Kurz *et al* (2005), that participants in this study legitimised and construct their accounts in several broad discursive strategies. All strategies function to build up the speaker’s own individual credibility and at the same time portray the participants’ account as an accurate and factual event or situation. First, I have shown how participants treat their practice as an accountable issue and, in the course of their actions, assert their intention to enhance their

practices as credible. Second, by attributing their practices to externality of events, they work to play down their own self-interest when promoting their homeopathic practices. Third, by persuasively invoking the actions that they do, participants can use their attributions to divert responsibility away from themselves to the event, previous experience or situation, thus demonstrating how people in analogous contested and controversial contexts co-construct social realities through talk specifically to perform specific social actions in verbal interaction (Horton-Salway 2001; Wooffitt 1992). More than this, it is a way to demonstrate the potentially disempowering constructions of homeopathic practice in play during the interactive question–answer sequencing.

With reference to Chapter 1, the wider sociological issue of marginalisation was discussed, highlighting that the boundaries of the institution are defined by notions of (un)acceptable practices made relevant by the social actors in the field of both mainstream medicine and homeopathy. The notion of what is an (un)acceptable taken-for-granted normative practice is socially constructed and constituted over multiple discourses. Therefore, the notion and subsequent effect of marginalisation *in situ* varies over health-related contexts and settings and is a potential effect of the participants' contingently formulated situated practice (Foucault 1970; 1973, 1980; Wetherell 1998). To clarify, Carabine (2001), informed by post-structuralist perspectives (Foucault 1970; 1973; 1980), defines a discursive strategy as:

the ways that a discourse is deployed. It is the means by which a discourse is given meaning and force and through which its object is defined. It's a device through which knowledge about the object is developed...

(*ibid*: 298)

The movement of discursive resources and the discursive strategy demonstrates members' methods and the notion of accountability as an interpersonally managed situated practice. At the same time, one can also draw on the collective social patterning of occasioned normative expectations that produce continued inequalities when evaluating their practices, but, put in a genealogical context, the strategies oriented to are recognised as the socio-political consequences of discursive constraints and limitations on how to mutually and intelligibly account for homeopathy when contrasted with the dominant knowledge base attributed to the discourse of the medical mainstream.

I shall now discuss and evaluate the findings more specifically, arranged across the four discursive strategies: alignment-with-medicine, boosting-the-credibility-of-homeopathy, criticisms-of-medicine-to-justify-homeopathy, and managing-homeopathy-as-alternative.

9.3 The Alignment-with-medicine Strategy

Here, the interviewees account for their practices using a unique broad strategy in relation to practitioners. First of all, there is clearly the alignment-with-medicine, where interviewees describe their practice by orienting to notions of mainstream medicine and offer criticisms of the alternative 'lay' practitioner as a way of making particular interpersonal issues salient, making their own practices credible— this as a way of attending to and managing issues in relation to personal accountability by building up facticity, objectivity and authenticity into the inferences made. Moreover, the finding show that the practitioners who use homeopathy are

responding with particular actions in ways that counter the possibility of being viewed as lacking credibility.

These sorts of accounts display the interviewee's categories—and sets of categories represent what is relevant for the interviewees. The categories are spontaneously invoked and not put to them in any preceding question by the researcher, CC. Their use of categorisation corresponds to a large extent with Edwards' (1991) work on categorisation and with Wooffitt's (1992) and Potter's (1996) notion of fact construction and factual discourse, together with common discursive devices to perform specific social actions (Edwards and Potter 1992; Potter 1996).

First, I identified and examined how some of the interviewees in the alignment-with-medicine strategy describe their own practices in relation to medicine. For example, the 'I'm a homeopathic doctor' claim is invoked in a potential defensive orientation of their practices. In so doing, the language used by interviewees presents homeopathic practice in alignment with notions of mainstream medicine as a way of enhancing their own individual credibility and their own individual homeopathic practices. Also evident in the participants' talk is an orientation to construct notions of a criticised 'lay practitioner' or 'homeopath' by way of a contrast to the homeopathic doctor. With this broad strategy in play, the interviewees' accounts present homeopathic practice as a downgraded alternative to medicine, which has the wider effect of potentially and continually marginalising it in terms of mainstream acceptance (Wetherell, 1998).

These findings are consistent with those from previous studies by Cant and Sharman (1996) and Cant and Calnan (1991), where they describe alignment with conventional medicine as a strategy for gaining acceptance within the wider medical

field. Despite the identification of this strategy, homeopaths claimed that adopting orthodox practices was unacceptable. The homeopaths envisaged that practising on equal terms with orthodox physicians would result in discarding the image of the autonomous practitioner. Although there are potential benefits for some practitioners, there is also the downside of homeopathy not developing as a discipline in its own right, being continually downgraded as an alternative to mainstream medicine. Moreover, Degele (2005) argued that an ‘alternative setting’ is developed when practitioners categorise themselves in this way. In addition, Degele claims that if homeopathic practice is aligned with mainstream medicine then there is a level of non-acceptance with respect to proof of its plausibility, effectiveness and medicinal credibility. Therefore, if practitioners are viewed as aligning their practice with notions of medicine then the potential downside is their being portrayed as existing on the margins of the medical market—that is, as an distrusted alternative lacking in credibility. As a way of working up the status and credibility of homeopathic practice, practitioners are drawn into using medical jargon and concepts in bidding for acceptance and, thus, paradoxically sitting uncomfortably within medical theories to find degrees of acceptance (Degele 2005). These associations, however, are treated as an overly rational perspective in contrast to indexed social actions performed in talk (Horton-Salway 2001; Kurz *et al* 2005; Wooffitt 1992). Therefore, the findings in this present study offer an action-orientated approach to participants’ descriptions, experiences and events.

More specifically, participants, by orienting adopting the alignment-with-medicine strategy, draw upon medically oriented resources to deal with issues in relation to personal accountability and build up their status as practitioners. Hence, attention should be paid to the meanings of actions in particular contexts and

specifically to how the participants themselves make sense of their actions. In so doing, this makes descriptions difficult to challenge on the basis that accounts were heard as factual. The practitioners rely on the introduction of particular descriptions or sets of descriptions representative of what is made relevant. The practitioners place within the proposed analytical scheme, combined with specific discursive devices and various rhetorical formations, is designed to maximise the persuasive power of their descriptions in defensive orientations that make it difficult to challenge their views.

Significantly, the use of such descriptions is spontaneously invoked and not put to them in preceding questions from CC or the researcher. Clearly, this links to broader social notions and expectations of what is inferred by the references made to mainstream medicine. This framework, then, is used as a discursive resource to defend, justify and legitimise mainstream medicine as a powerful resource, the taken-for-granted, accepted yardstick for practice in everyday settings when accounting for homeopathic practice. By recurrently drawing upon a medical and a homeopathic dyad presented in a comparative frame, the practitioners make relevant, negotiate and sustain homeopathic practice as marginal in terms of mainstream acceptance (Wetherell 1998).

9.4 The Boosting- the-credibility-of-homeopathy Strategy

This strategy was observed throughout the research interviews with practitioners and during the consultation process. The strategy is presented in a similar fashion to alignment-with-medicine. By using the descriptions they do, the participants' strategies function to enhance their own individual credibility and that of their everyday practices. More than this, it is a way to attend to and manage issues in

relation to personal accountability by talking up homeopathy as a practice with potentially therapeutic benefits.

In answer to this, the participants portrayed their homeopathic practices as contested, problematic and potentially controversial. The participants accomplish this in a range of ways: by undermining potential criticisms, by using ‘troubles telling’ talk (Jefferson 1984; Jefferson and Lee 1992), or/and by deploying the (mundane) ‘X’ then (extraordinary) ‘Y’ device (Jefferson 1984; Wooffitt 1992), combined with various discursive devices designed to add persuasiveness and present their accounts as factual (Edwards and Potter 1992). At the same time, homeopathic practice is negotiated, produced and sustained in everyday contexts as a downgraded alternative to those wider notions of mainstream medicine that are the accepted yardstick for practice. Moreover, by designing their accounts in specific ways, the participants emphasise particular features to make their descriptions appear solid and factual discursive productions. Therefore, it is clear that the participants’ descriptions of homeopathy are not a neutral reporting of its characteristics. In presenting their descriptions as they do, participants attend to inferential issues regarding homeopathy’s therapeutic benefits. The practitioners who make sense of homeopathy in this way are responding with the actions that they do to counter the possibility of being viewed as lacking credibility.

In the homeopathic consultations, the boosting-the-credibility-of-homeopathy finding is represented through naturally occurring ‘institutional talk’ in the practitioner/patient interaction. Therefore, the strategy is presented in a more ‘naturalistic’ form compared to the research interview. Here, the participants are observed to be undermining a potential criticism and portraying homeopathy as a culturally contested ‘type’ of practice. In a similar way to the research interviews,

homeopathy is portrayed through a defensive orientation of their practices; that is, as a practice with therapeutic benefits. However, the commonsense assumption prevalent through the accounts is the way the participants spontaneously categorise non-orthodox practices as counter-hegemonic, alienated by the dominant cultural medical order.

In both contexts, the participants adopt common discursive devices, which are consistent with previous studies, to present their accounts as factual from a perspective whereby verbal interactional interviews and consultations are a site of social interaction where participants get things done. Similar associations within different contexts have been illustrated in prior studies by Horton-Salway (2001), Kurtz *et al* (2005) and Wooffitt (1992). It is noteworthy that the participants in this present study talk about homeopathy in ways similar to those in which other people have been found to talk about their contested and controversial paranormal experiences, suggesting the difficulties in making potentially sceptical homeopathic practice credible (Wooffitt 1992). In talking this way, however, the downside is to position homeopathic practice as an alternative to wider notions of mainstream medicine, or as a problematic practice, resulting in and presenting homeopathy as a 'last-resort-form' and 'type' of practice located in a culture of scepticism. In stark contrast, the traditional approach to homeopathic research presents an overly rational perspective where participants' views tend to be treated and based on a systematic evaluation of accurate truths.

However, consistent with the boosting-the-credibility-of-homeopathy finding, a study conducted by Cant and Sharma (1996) identified through a strategy concerning professionalisation that there has been a consistent effort from practitioners to attach themselves to the scientific paradigm as a way of boosting the

credibility of homeopathic treatment. They report that patients become alienated from practitioners who align their practice with orthodoxy. The downside to Cant and Sharma's findings is the suggestion that boosting the status and credibility of homeopathic practice alienates non-medically trained homeopaths and their patients who look for autonomy over their health.

This finding shares concerns with Cant and Calnan (1991), who argue that the boosting of homeopathy was attempted by making relevant the way it differs from mainstream medical approaches. Moreover, Cant and Calnan (1991) identified a way of boosting the credibility of homeopathy through talking it up as offering a wider approach to the patients' health status in contrast to mainstream medicine—portraying the action of homeopathy as potentially therapeutic. Their findings present homeopathic practice as offering a broader approach to treatments than the curtailed mainstream practices by taking on board a patient's societal relationship, mental and physical symptoms, as distinct from the merely physiological dimension. This process was accomplished by demonstrating the demarcation between mainstream medicine and homeopathy through portraying the action of homeopathy, using opposing principles, as potentially therapeutic. As a further example of work that boosts the credibility of homeopathy—defined as medical treatments that reputedly act in an unscientific mode of action and with an opposite mechanism to that of orthodox medicine—I cite Degele (2005). By describing homeopathic practice in this way, Degele suggests that it becomes demarcated from orthodox medicine by making differentiation a significant and deciding issue.

In this present study and in previous research, the use of this strategy allowed the participants to endorse, legitimise and manage issues of personal accountability for their own everyday homeopathic practices. Aspects of mainstream medicine were

unquestioned resources, and were drawn upon as a comparison to boost the credibility of homeopathy. In this way, homeopathy as a resource, when it was being defined as positive, was consistently compared to mainstream medicine.

The wider effect of accounting in this way is to present homeopathy in a culture of scepticism, potentially and continually on the margins of mainstream acceptance. Significantly, the resource of mainstream medicine goes largely uncontested as the participants negotiate their accounts in relation to the taken-for-granted evaluative principle of mainstream medicine, which is undoubtedly an available located historical and culturally shared social resource. There were no findings to suggest that mainstream medicine should be dismissed; rather, it is viewed as a site of challenge by a potentially marginal or subordinate group of participants.

9.5 The Criticisms-of-medicine to justify-homeopathy Strategy

This penultimate strategy is identified in the research interview with patients and in the homeopathic consultation process. Through ‘lay versions’ of their experiences, homeopathic practice becomes presented as problematic and troubled in a defensive orientation of their practices as an alternative when contrasted with notions of mainstream medicine. The strategy functions to enhance the credibility of the interviewees’ practice as credible and is a way to manage issues in relation to personal accountability. In talking up their practice in this way, the interviewees’ strategies work to counter any potential criticism that they are discredited for looking to homeopathy as a form of treatment. The interviewees invoke criticisms and the failures and limitations of mainstream medicine as a basis for looking to homeopathy as a treatment option. These accounts rely on a range of ways of presenting their

descriptions so that they attribute the decision to use homeopathy to the failure of medicine, through ‘troubles telling’ talk (Jefferson 1984; Jefferson and Lee 1992) or by deploying the (mundane) ‘X’ then (extraordinary) ‘Y’ device (Jefferson 1984; Wooffitt 1992), adding persuasiveness to their potentially factual accounts (Edwards and Potter 1992). At the same time, the accounts represent the interviewees’ place within the proposed analytical scheme (Wetherell 1998). These ways of accounting, combined with various discursive devices, are designed to maximise the facticity and persuasive power of the social actions being performed (Edwards and Potter 1992).

It is also significant because this links to broader social notions of what is inferred by references to mainstream medicine. By recurrently drawing upon medical and homeopathic practice as binary oppositions, the interviewees present a comparative frame that works to sustain homeopathic practice as a ‘last-resort-form’ and alternative ‘type’ of practice. This framework is then used to justify, argue and legitimise mainstream medicine as the taken-for-granted, accepted yardstick for practice in everyday settings when accounting for homeopathic practice. Like Kurz *et al* (2005), Horton-Salway (2001) and Wooffitt’s findings (1992), the interviewees’ descriptions in this present study are treated as equally valid versions of socially and mutually intelligible sense-making practices where they get things done in interaction. The apparently critical orientations towards biomedicine can be understood as common dynamics at play in different types of homeopathic encounters. Furthermore, in the homeopathic consultation process, participants are observed to be looking to homeopathy by presenting their potential troubles in relation to criticisms, failures and disenchantment with mainstream medical practices. This comparison has also revealed ways in which expectations concerning the patients’ role in attending the consultation are treated. Significantly, the use of such constructions is spontaneously

formulated during the consultation process. As they do so, the participants orient towards this strategy as a way to sustain the potential to participate in similar institutional norms of medical encounters, albeit very different treatment ideologies. A more general point is made about the practitioner/patient relationship that stresses their apparent congruity with the prevailing contemporary dominant medical order and the dominance of mainstream medical practices.

From an overly rational perspective, these findings are consistent with a study conducted by Cant and Sherman (1996), who argue that patients seek homeopathic treatment because they are disillusioned with scientific and technocratic medicine, maintaining that patients want more autonomy and a positive interaction during the consultation. They cite both medically qualified and non-medically qualified homeopaths as the source of this information. Furthermore, Frank (2002) argues that disillusionment with biomedicine was expressed by patients who used homeopathy as a final treatment option because of this disenchantment. In taking this ‘you are my last hope’ position, patients are viewed as defining homeopathic practice as positioned outside the prevailing scientific mainstream (Frank 2002). Cant and Calnan (1991) presented similar findings. Indeed, they suggested patients looked to homeopathy as a ‘last-resort’ ‘type’ of treatment after apparently receiving inadequate conventional treatment, harbouring scepticism of drugs, and desiring a longer consultation. Although informative, the downside of these studies is that they do not examine in detail how people talk about and account for their homeopathic practices as social actions *in situ*. Rather, they offer a ‘realist’ view that takes for granted that language represents accurate events, situations and experiences. It is worth saying that these kinds of critical views of mainstream medicine have serious implications. The use of a rhetoric of comparison and differentiation justifies factual claims linked to the

continuing marginal properties of homeopathic practice, being represented as talk, performing various social actions and entwined with the wider context of a sustained ‘mystifying’ of homeopathy as an alternative.

9.6 The Managing-homeopathy-as-alternative Strategy

In the final strategy, homeopathic practice becomes presented through lay-versions and in a defensive orientation of their practices as contested, controversial, potentially irrational—out of the ordinary—and downgraded as an alternative ‘type’ of practice compared to notions of mainstream medicine. This strategy was identified in the research interview with patients and in the more formal institutional setting of the homeopathic consultations. The participants introduce personal factors to defend their use of homeopathy, enhance the credibility of their practices, and attend to and manage issues of personal accountability by working up their descriptions as factual.

At a basic level, the personal standpoints taken are constructed from pre-existing, historically located discursive resources that are available, made relevant and reworked to produce specific rhetorical functions, which are wholly dependent on the immediate situated business at hand. The range of ways in which the interviewees accomplish this includes using ‘troubles telling’ talk, (Jefferson 1984; Jefferson and Lee 1981), combined with various discursive devices to talk up the persuasiveness and enhance the authenticity of the actions being performed (Edwards and Potter 1992). In addition, the participants introduce personal factors that offer homeopathy as an alternative ‘type’ of practice and that account for their individual use of it. By using the descriptions that they do, therefore, the participants enhance the credibility of their individual practices. For them, however, individual credibility is

accomplished only through specific constructions of homeopathy that orient to it as a sensitive practice that works, by contrasting it with notions of mainstream medicine and medical discourse, to continually position it on the margins of mainstream acceptance.

What is demonstrated here is how the participants, through flexible use of the discursive resources, and discursive devices made available, frame everyday homeopathic practices as problematic during social interaction. The personal standpoints taken are constructed from available discursive resources that are contingently produced, negotiated and reworked to serve specific rhetorical functions wholly dependent on the situated rhetorical business at hand. It is important to see that attention is paid to the meanings of actions in particular contexts and, in particular, to how the participants themselves make sense of their actions. This verbal interactive perspective is in alignment with prior contested and controversial studies by Horton-Salway (2001), Kurz *et al* (2005) and Wooffitt (1992). The potential downside is that by constructing their accounts in this way, interviewees work to highlight the controversial and contested knowledge claims. There seem to be more factors at work in this present study. Essentially, one of them is the predictable framework in terms of the contrast between homeopathy and mainstream medicine. Taking the homeopathy/mainstream medical perspectives as a whole in terms of practice styles, it is rather positioned as a heterogeneous group. The participants orient to apparently experience this pressure and work to explicitly differentiate according to the demands of scientific evaluation. However, in doing so, I argue that their constructions may lead to a backlash against homeopathic practice as a credible alternative option. Note also that during both the research interview and homeopathic consultation, interviewees and participants offer a broad consensus linking homeopathy to

‘alternative’ lifestyles, counter-culture and political exclusion, implying that there is a potentially antagonistic, polarised and counter-productive relationship with mainstream medicine.

In a similar vein, and though criticised for its overly rational perspective, previous research by Cant and Calnan (1991) showed the notion of homeopathy being described as alternative through the way that homeopathic practitioners identified a philosophical conflict with orthodoxy, and saw their role as alternative on this basis. Equally, Degele (2005) illustrated the development of the ‘alternative setting’ by illustrating the system of homeopathy in therapeutic terms – that is, homeopathy being defined through medicines that are reputedly alternative and act in an unscientific mode of action and with an opposite mechanism to that of orthodox medicine. Furthermore, Degele (2005) described a demarcation criterion through the strategy of the ‘alternative setting’, which explicitly names and positions homeopathy in a culturally shared scepticism as an alternative to orthodox practices. At the same time, this political exclusion works to fragment and divide homeopathic practices, so at a micro and macro-social level their contested knowledge claims are weakened by complementing or legitimising the alternative to mainstream medicine by not questioning its hegemonic position. In light of the present data it is conceivable that the broader discursive patterns of homeopathic practice as an alternative serve to sustain mainstream medicine as the dominant medical approach and homeopathy as marginal (Wetherell 1998). Ironically, this discursive effect is produced in their potential outright rejection of it.

Chapter 10

Evaluation of the Study

To demonstrate the research design as rigorous, in this chapter I critically evaluate the present study by discussing four recognised discourse analysis criteria. First, there is a discussion of coherence in terms of the findings across data sets and through the citing of prior studies. Second, in the section ‘participants’ orientations’, I argue why it was essential to be data driven and identify what the participants made relevant, consistent and different. Third, I argue that an exception is related to coherence. Fourth, I demonstrate that my focus was to highlight the discursive resources and discursive devices used by the participants, which produced specific effects and ultimately created new problems.

Fifth, under the heading ‘fruitfulness’ I claim that the originality of my thesis lies in its ability to generate theoretical, methodological and practical implications for DA and homeopathic practice. Sixth, under the heading ‘trustworthiness’ I argue that there is a consistency demonstrated throughout the transcriptions across data sets. By way of a conclusion, the chapter closes with a summary of the research undertaken.

10.1 Validation of the Study

As a way of validating this present study there are various evaluative criteria, namely coherence, participants' orientation, new problems, and fruitfulness—proposed by Potter and Wetherell (1987)—and the notion of trustworthiness (Taylor 2001) to warrant the findings of this type of work. Each offers an evaluative perspective on the various aspects that make for a robust study—in which my analysis satisfies these recommendations.

10.1.2 Coherence

I begin this assessment by first introducing the notion of 'coherence'. When making analytical claims concerning a section of discourse, they should demonstrate coherence and show how the social constructions of homeopathy produce specific functions and effects. If there are discrepancies across the data sets then the analysis has less credibility. Once a pattern within the data is 'discovered', the goal is to look for inconsistency and diversity. Therefore, inconsistency is suggested as a feature of naturally occurring talk and the analyst should identify where participants orient to this kind of pattern.

I argue that the coherence of the findings is demonstrated in two ways. First, an aspect of coherence is explored and developed in the micro-patterns of the findings—that is, how the social actions *in situ* are performed by the participants to provide four broad discursive strategies as findings. In so doing, the finding that participants deploy broad discursive strategies to make sense of their experiences provides a basis for a coherent analysis of many of their responses. Hence, the deployment of discursive resources made available to produce these patterns, and

which are treated by the participants themselves as coherent, were demonstrated throughout the alignment-with-medicine, boosting-the-credibility-of-homeopathy, criticisms-of-medicine-to-justify-homeopathy, and managing-homeopathy-as-alternative strategies. The inconsistencies representative over the strategies serve as a validation by the participants themselves. In each of the analytical chapters, a variation of the talking up of personal credibility and the status of homeopathy is central to the members' mutually intelligible sense-making practices. The consistency of the findings of three strategies made relevant in the research interview consultations show that there is a wider cultural scepticism about the validity of homeopathic treatment being culturally accepted by the main actors in the field. In this sense, my analysis is coherent.

Second, previous studies have shown that there is consistency from a research perspective because the discursive strategies the participants oriented to in this present study were noted by earlier writers. The notion of alignment-with medicine was identified by Cant and Sharman (1996), Cant and Calnan (1991), and Degele (2005). Boosting-the-credibility-of-homeopathy was illustrated by Cant and Sharman (1996) and Cant and Calnan (1991). The Criticisms-of-medicine-to-justify-homeopathy strategy was discussed by Cant and Calnan (1991) and Frank (2002). Homeopathy-as-alternative was made relevant by Cant and Calnan (1991) and Degele (2005). In so doing, findings from previous studies offered a research context in which to proceed with this current study. From a DA perspective, and in previous studies, participants were observed to be deploying various discursive devices to accomplish specific social actions. Kurtz *et al* (2005), Horton-Salway (2001) and Wooffitt's (1992) research findings show how problematic interpersonal issues in relation to personal accountability can work to position specific groups in contested and controversial

knowledge claims about the validity of their practices. These similarities between discursive device uses in situated practices, the particular functions they serve, and the social actions that speakers thereby engage in, offer more credibility to the coherence of my claims.

10.1.3 Exceptions

Apparent exceptions to the analytical scheme are specifically relevant to the evaluation of coherence (Potter and Hepburn 2005; Potter and Wetherell 1987). In this study, not all the participants accounted for homeopathy through the discursive strategies described above. Rather than identifying in this thesis a precise exception, I make the claim that homeopathy as a category and discursive resource is presented via multiple descriptions. In making this claim, I demonstrate how an exception to the proposed analytical scheme may be applied to validate the analytical claims being made.

10.1.4 Participants' Orientations

Another technique I used to validate the present study was the participants' orientation. Potter and Wetherell (1987) argue that dictionary definitions are of little interest to the discourse analyst when considering the discursive resources made relevant by the participants. When applying discourse analysis it is fundamental to display a concern regarding definitions the participants spontaneously formulated during their interactions. Participants' orientations are those that are a concern in the talk itself, either as a topic of the talk or made relevant by the participants themselves. In terms of ethnomethodology, they are members' accounting practices (Garfinkel

1967). The research interview setting and the formal institutional homeopathic consultation process, it was imperative to be data driven. Note that it is fundamental to identify what the participants made relevant, consistent and different.

This variability in the descriptions allows the indexical action–orientation features of language to be examined. Throughout all the analytical chapters (6,7 and 8) and the four discursive strategies there have been instances of variability and consistency, highlighting the general features of socially performed everyday talk about homeopathy. The participants’ descriptions are not simply neutral representations of events but are part of an interactive indexical interaction. When a description is recognised and occasioned, it then becomes part of a practical and enduring social action. Suffice to say, formulations are not, then, neutral theoretical outlines but concise context-specific consequences related to future actions. This was demonstrated in the way that the participants enhanced the credibility of their practices through defensive orientations. So the focus of analysis is on the inferences and attributions of the actions they perform. By considering the notions of indexicality, reflexivity and the documentary method of interpretation, a sense of structure emerges as a practical accomplishment of everyday interpretive processes.

From this interactive perspective, the object of analysis is not to begin with a list of pre-established and theory-led questions or concepts to be explored, nor to approach the data seeking broad societal differences between, for example, medical or non-medical homeopaths with their patients, and how they may define themselves and their experiences. Rather, the focus is to investigate the participants’ orientations and not to impose an analyst’s interests and stance on the research data and processes. This point is related to a feature that takes into account that talk is intelligibly organised; that is to say, it acknowledges that conversations are organised as

interpersonal accomplishments and activities. In responding to each other in question–response verbal sequences, participants display their interpretations and understandings of prior invocations in their own invocations, which can be accepted or rejected in a subsequent utterance. Moreover, this principle adheres to the notion that analysis should be driven by participants’ interpretations and concerns, as displayed in their utterances, in contrast to being driven by the analyst’s intuition, theoretical concepts or self-interest (Wetherell 1998; Wooffitt 1992).

Hence, my analysis was not led by my theoretical assumptions about homeopathic practice and its potentially influencing factors. The theoretical and methodological implications were developed during and after the completion of the analytical phase. All participants’ orientations have discursive implications and should be investigated for a broader socio-political, historical and cultural grounding that accounts for the shape, content and character of the interaction (Wetherell 1998). As a result, the analyst is expected to identify and address the new problems and is evaluated the specific effects (Potter and Wetherell 1987).

10.1.5 New Problems

When considering new problems, my focus was to demonstrate the discursive resources and discursive devices contingently mobilised and used by the participants for specific effects. In carrying this out, new problems were created. In the context of this present study, I identified that, in the variety of settings and through the participants’ orientations, homeopathy becomes potentially and continually marginalised in terms of mainstream acceptance through the discursive device of contrasting homeopathy and notions of conventional medicine in a binary opposition,

two-set framework. This finding was identified throughout all the analytical chapters and over the four discursive strategies. However, I must stress that this is not the only way the participants talked about homeopathy or structured a credible and persuasive response. Everyday talk about homeopathy inevitably produced multiple descriptions that presented contradictions if taken at face value. Moreover, the participants presented their contingently formulated accounts as authentic and factual series of events. However, the particular accounts that focused on concerned the wider effect of positioning homeopathic practice as a contested and controversial knowledge claim situated in a culture of scepticism.

On a more fine-grain interactive level, one way of dealing with new problems was for the participants to close down the conversation through their responses to the preceding utterance, which was in turn dependent on the indexicality and reflexivity of the preceding action being performed. Moreover, by drawing upon the discursive resources made available, participants provide confirmation that accounts are action-oriented, situated, and context-specific. The point then is that formulations are not produced as neutral, accurate descriptions of everyday activities; rather, the participants performed sequences of social action *in situ* through defensive orientations, criticisms and justifications of their practices. In so doing, through talk about homeopathy, the participants provided fruitful insights and a broad picture of the homeopathic environment and the potential difficulties of making their practices credible.

10.1.6 Fruitfulness

The criterion of ‘fruitfulness’ refers to the potential for the analytical approach to open up new possibilities in terms of producing original explanations. If findings

can be used to generate new avenues for studying the research, then they gain greater credibility. This study provides some insight into the specific actions and the broad discursive strategies deployed by participants with the wider effect of positioning homeopathy on the margins of mainstream acceptance. The originality of my thesis lies in the applied and innovative DA framework and its broad range of participants. It forms a unique theoretical and methodological contribution to DA literature and shows that for the very people who advocate homeopathy, managing their personal credibility is accomplished only through specific ways of accounting. In doing so, the wider effect of the discourses in play is to present homeopathy as situated in a culture of scepticism, oriented to as an alternative troubled 'type' of practice positioned on the fringe of the modern medical market. In making this distinction, the boundaries of what is and what is not acceptable is judged on mainstream medical territory. In this way, participants continually display the contested, new and controversial properties of their mutually intelligible accounting practices when making claims in a medical/homeopathy dyad.

The broader claim of homeopathy on the margins has practical implications for policy and education in homeopathy and future research in homeopathy or in potentially similar medical encounters and DA. The consistency of the replication and the extent and scope of the analytical patterns and procedures over the course of three analytical chapters adds to aspects of trustworthiness.

10.1.7 Trustworthiness

In the application of DA, the researcher generally opts for accurate audio-taped verbatim transcripts that have the potential to be legitimised and approved as

authentic by the participants. However, in this study I have applied a methodological and theoretical framework to the data extracts. Subsequently, it is worth noting that this in turn could produce analytical findings not initially obvious to the participants (Taylor 2001).

Moreover, the complexities of transcription work is argued by authors Lapadat and Lindsay (1999), Mishler (1991), and Tilley (2003), who question the notion that transcription is an accurate objective replication. Rather the transcripts are presented as 'text', which is a sensitive and delicately constructed representation. Taking this view on board, in this present study the interpretative, analytical and theoretical influence on the texts is not inclusive of all the contextual information such as tonal qualities or timed pauses commonly found in the Jefferson-lite form of transcription. Arguably, the transcripts reflect the aims of the study since 'the choices that researchers make about transcription enact the theories they hold and constrain the interpretations they can draw from the data' (Lapadat and Lindsay 1999). In this way, elements of trustworthiness are addressed by applying a consistency of transcription across data sets. In this way, rigour was incorporated using this strategy across all the extracts.

Finally, trustworthiness is also concerned with the notion that pristine generalisations can be transferred from this present study to other research projects. The perspective in the present study acknowledges that descriptions are actively built by the participants through verbal interactive sequences. In so many ways, each utterance is context-specific to a specific accounting activity (Wetherell 1998). However, the broad strategies in play may represent commonalities in other Complementary and Alternative Medicine (CAM) settings. This point is elaborated upon in the following chapter.

10.2 The Main Analytical Points of the Study

For the analysis in this present study, I applied an innovative analytical framework informed by discursive psychology perspectives, which is novel for homeopathy. DA led to original and important findings about how apparent experiences are accomplished in interaction, through participants' orientations in verbal interaction, through talk and over discourses rather than in clearly defined factual frames of reference pre-existing freely in the 'social world'. This is in contrast to previous research by scholars on this topic, where views are considered stable entities that are represented as accurately portrayed through participants' descriptions. As there are no relevant DA studies in homeopathy, I drew on previous studies that related to the literature review and to practitioners' views concerned with the credibility of homeopathic practice, where homeopathy becomes demarcated and subsequently positioned on the margins of mainstream acceptance.

In total, four discursive strategies were identified that function to enhance the credibility of the participants' practices as persuasive, authentic and factual: alignment-with-medicine, boosting-the-credibility-of-homeopathy, criticisms-of-medicine-to-justify-homeopathy, and managing-homeopathy-as-alternative.

In particular, the findings show how practitioners defend their practices as credible by either aligning them with medicine and criticising the 'alternative' or boosting the credibility of homeopathy by invoking and formulation persuasive descriptions or undermining potential criticisms. Furthermore, patients invoke criticisms and describe the failures of conventional medicine, which is attributed as a basis for looking to homeopathy. This is presented in the criticisms-of-medicine-to-justify-homeopathy strategy. Note also that patients introduce personal factors to

defend their use of homeopathy. Participants attend to issues of credibility vis-à-vis their practice, managing their personal accountability by working up their descriptions through activity sequences as solid, factual discursive accomplishments and by attending to attributional issues of responsibility to counter potential challenges to the claims made. Predominantly, in the managing-homeopathy-as-alternative strategy, participants reject mainstream medicine and make explicit homeopathy as an out-of-the-ordinary, alternative practice outside the dominant medical realm.

In the formal institutional setting of the consultations, I identified the strategies criticisms-of-medicine-to-justify-homeopathy, boosting-the-credibility-of-homeopathy and managing-homeopathy-as-alternative, which were co-constructed by both practitioners and their patients as ways to enhance their individual credibility. In understanding homeopathy and their expectations of it as a form of treatment, participants draw upon dichotomised categories such as medicine/homeopathy, combined with various discursive resources and devices to talk up persuasiveness and factuality to their accounts—all of which adopt wider notions of mainstream medicine as a primary source of comparison.

Throughout all of the extracts, notions in relation to mainstream medicine and homeopathy are used as the discursive resources available within a two-set class contrasting discursive resource that sustains everyday homeopathic practices on the fringe. Whilst homeopathy is made relevant, contrasted and evaluated in this way, the potential and apparent continued marginalisation of it in everyday, research interview and medical settings will inevitably persist.

Chapter 11

Reflections

Here three overarching insights can be distilled from which I discuss the implications of the research process and the overall contribution of the study. First, I discuss reflexivity and the analyst's role, followed by an outline of my experiences of participating in the research interview process. Second, I discuss the theoretical, methodological education, policy, interdisciplinary and practical implications of the study. Furthermore, in this section I outline the limitations of this current study, what I would do differently to improve upon it, future research directions, and consider the transferability of the findings to analogously contentious contexts. Third, a brief conclusion completes my reflections.

11.1 Reflexivity of a Practitioner-Research(er)

This notion of reflexivity suggests that descriptions are not merely about or representing something: they are also doing something. They are part of being implicated in a practical activity (Potter 1996). Here, the issue of reflexivity refers to the relationship between the content of the research and the researcher's theoretical and methodological positioning. Potter and Wetherell (1987) and Edwards and Potter (1992) argue that how one treats the notion of reflexivity in the production of a social science text is an essential part of the research process. They claim that the analyst's

questions, assumptions and design of the study are just as much a focus as a participant's text. Furthermore, the analyst's account of the participants' mutually intelligible language use is as much a construction and has as many action-orientated aspects as the constructions and representations of homeopathy that are under scrutiny. In qualitative research, the issues surrounding reliability and validity are apparent. The choice of paradigm assumption and the demonstration of quality, rigour, and trustworthiness throughout the study reflect the level of appropriate reliability and validity criterion. No research method can truly claim to be constructed according to an infallible criterion. Therefore, a reflexivity discussion offers a way to view and redefine the multiple established claims and counter-claims.

A vibrant discussion of the sociology of scientific knowledge, influenced by the *Tu quoque* critique, commonly known as 'there's another', or 'you too', provided my study with a perspective upon which to base a critical stance (Potter 1996). This approach is not intended as a self-contradiction. In preference, it is viewed as an investigation in which an exploring reflective lens is applied. Therefore, in contrast to suggesting that scientific texts are neutral, transparent descriptions, a focus on my own contingency and artificiality in the constitutive text is unravelled as part of a review.

Another aspect of reflexivity taken into account is textual reflexivity, which refers to the writing representations and cogency of a text. Here my own social text is constructed, considering issues regarding how a traditional scientific text would be received, by examining how science operates within this, and by focusing on the ways scientific knowledge is objectively formed. The intention is that, by applying constructive practice to the research process and to the final thesis, the tension between claims to scientific knowledge and objectivism in scientific accounts and

textual forms is highlighted (Ibanez 1994; Macbeth 2001; Potter 1996). As this present study is grounded in a discursive psychology framework based on the socially constructed nature of accounts, so too must this very thesis be a socially constructed product, thus leaving it available to a deconstructionist critique (Derrida 1976).

This suggests that the very discursive resources and discursive devices illustrated throughout extracts are adopted to explain the actions, events and situations of my research experiences. In so doing, I developed a rhetorical ‘realist’ effect through the choice of specific discursive resources presented in persuasive activity sequences (Potter and Wetherell 1987). Consequently, through specialist language use, I construct a particular version for specific actions and effects.

To reiterate, the text in this present study is not a systematic record of accurate facts; rather, it is a complex social accomplishment (Foucault 1983; Gergen 2000; 2001; 2001a; 2001b; 2001c). As I make various claims in each of the chapters, I acknowledge that the claims are neither neutral nor transparent descriptions of social phenomenon. The point of highlighting this notion is not to reject realism, representation, or empiricism; rather, it is to be aware of the self-referring fashion of fractures in the referential discourses that I present and not to repair or ignore such tensions (Potter 1996). Lastly, whilst this thesis was itself constructed I wrote in a style akin to conventional realism in the various sections of the thesis. As a result, in this present study the ‘I’ is not exempt from indexical and reflexive considerations of how descriptions are worked up as factual to serve specific functions and effects.

Notably, positional reflexivity has a focus on the autobiographical and clinical attachments when articulating one’s analytical situated self (Macbeth 2001). Acknowledging what Taylor (2001) terms ‘inside status’—that is, that I currently have experience of clinical homeopathy in the role of a trained NHS practitioner—

may suggest that there are elements of sameness with, and potential bias towards, the participants' claims.

In the realisation of the potential impact of this status quo, Wetherell and Potter (1992) argue that mutually intelligible, commonly shared attributes can be viewed as either complementing or undermining the research process. My own professional role raised issues regarding power relations in the interview context. I had set the agenda through an interview schedule and thus influenced the outcomes considerably by the questions I asked. On a practical level, there were possible advantages, for example in the way I potentially benefited from the knowledge of where to pursue the recruitment of participants.

Theoretically, one advantage I may have is that I also question the efficacy of homeopathic medicine. From this personal standpoint, I can only empathise with the potential absurdity of the homeopathic dilution principle and so forth. However, patients were heard to advocate for homeopathic medicine and voice detailed significant yet unexplainable 'therapeutic' benefits, representing a source of credible evidence (Reilly 2006)—albeit anecdotal. My interest in homeopathy lies in the context of the homeopathic consultation or encounter, where a registered practitioner would bring his or her skill base into the encounter with a patient and work, from as much as is realistically possible, a patient-centred position. More than this, I have reverence for homeopathy's basic principle—the notion of 'treating' the person rather than the disease. Displaying and attending to empathy in relation to the patients' illness experience is my primary prerogative. I would argue that the distinguished features of this fundamental phase can be utilised as a basis to provide the patient with evidence of my ability to understand their situation (Ruusuvuori 2005). Clearly, by attending to and managing potentially sensitive interpersonal issues and paying

careful attention, the homeopathic analytical framework offers a criterion in which to learn how patients frame and talk about their experiences of real and debilitating illness.

Each practitioner has undoubtedly acquired a wide range of skills and is given the space of the homeopathic consultation to act as a facilitator and enabler for the patient. As a result, this perspective allows me the space to focus on developing aspects of professional, good and informed practice in contrast to repetitive and idle arguments concerned with proving homeopathic credibility in an often unsuitable conventional medical paradigm. On no occasion in the thesis do I claim to have absolute knowledge about informative insights regarding homeopathic practice. Possibly, there were advantages to being able to explore intricate homeopathic principles, theories and areas of contention where perhaps an outsider might have little knowledge. Therefore had I not been involved with homeopathy at a professional level, the nomenclature of the everyday homeopathic jargon may have presented unforeseen dilemmas.

11.2 Experiences in the Research Interview

Rather than being merely a data-collection exercise, the semi-structured research interview is more of an open-ended, flexible research perspective requiring attendance to active listening, with ingredients that include attending to the notions of encouragement, support, reassurance and empathy (Watson and Weinberg 1982). The research interview is quite often treated as a natural pathway to revealing accurate findings that are by and large generalisable outside the interview context. However, in this study and by adopting a discourse analytical perspective, the interview is seen as

an important site of social action where contextual information is relevant to the orientations made by the interactants themselves.

As a matter of course, I adopted elements drawn from prior experiences in the homeopathic case history process to develop a flexible and dynamic interviewing style. Similarly, the homeopathic approach and subsequent case-taking technique is set in a well-established social context where one generates and prompts discussions. The aim is to facilitate the individual or participant to negotiate the relevant features of their illness characterisation (Di Blasi and Kleijnen 2000; Kaplan 2001; Kayne 1997; Mercer 2001). In addition, by completing a Bachelor of Science (Hons) study in homeopathy I gained expertise in data collection, qualitative research interview technique and narrative analysis.

11.2.1 The Research Interview Debate

Current debates in social psychology, and in particular discursive psychology, discuss the merits and implications of using the analytical materials of the research interview in contrast to a shift to working with the hotly contentious notion termed ‘naturally occurring talk’ (Griffin 2007). In engaging with the argument, Potter and Hepburn (2007) advocate the open-ended interview is the ‘default data generation’, maintaining that the activity of the research interview is primarily an artefact of the given topic. Their interest is to promote naturalist materials, suggesting that they offer that added value.

In the consultative process of this present study, the participants’ talk is viewed as ‘naturally occurring’, in that it is uninterrupted by the researcher, as applied in more formal institutional settings (Drew and Heritage 1992, 1992a; Hutchby and

Wooffitt 1998; Potter and Hepburn 2007). Moreover, from this perspective the research materials are viewed as closer to the notion of ‘naturalistic’; that is, the consultations or homeopathic encounter would still be ‘done’ irrespective of the researchers activities (Potter and Hepburn 2007).

However, in an early debate regarding natural and contrived data, Speer (2002) highlights the frailties and objectivity in any piece of qualitative research. One concern was that in order to gain access to recorded data participants have to read, understand and sign a document appropriate for informed consent. Arguably, turning the MP3 player or tape-recorder on and off involves various levels of invasion. Speer (2002) argues that in doing so these research practicalities already contaminate the purity of the interview or the so-called naturally occurring data collection process. In a nutshell, Speer (2002) argues that all data is research-prompted and thus is an artefact. More than this, Speer (2002) claims that if all data is contrived, why do qualitative researchers assume that certain types of data are purer than others? She states: “This cause-effect model seems peculiar in the context of a research field that spends much of its time criticizing such frameworks as both deterministic and simplistic (Speer 2002: 519)”.

In sum, the data collection practices offer numerous potentially relevant contexts providing diversity that “encapsulates a broad, complex and contradictory set of epistemological frameworks, methodological processes, research techniques and analytical procedures” (Griffin 2007a).

I acknowledge Griffin (2007) when she debates the imperfectness of the research interview and agree that as an active reflective researcher engaging with one’s participants there are moments when one’s agenda mirrors theirs. Arguably, there are instances when events can be interpreted and argued for as either ‘etic’ or

‘emic’,¹⁰ highlighting the research interview as a dynamic analysable activity in its own right (Griffin 2007:260).

11.2.2 Homeopathy and the Research Interview Process

From a homeopathic perspective, quality research interviewing is in its infancy, but I found it a fruitful and useful place to start. By active interviewing, the findings demonstrate how the participants themselves view and practice homeopathy by the invoking of intelligible, culturally shared accounting and reasoning practices—albeit from a specific research interview context. Without this information, and by going directly to the naturally occurring data of the homeopathic consultation, the topic of homeopathy from a DA perspective has fuzzy borders, leaving a poorer understanding of the social actors who practice in such a contested and controversial arena.

In this study, the focus was to draw on the interviewees’ experiences of the homeopathic therapeutic process, carried out carefully in a non-exploitative way. As discussed in Chapter 5, an interview protocol was drawn up containing an opening question ‘Could you tell me something about yourself?’ to ease the interviewees into the interaction by allowing as diverse a response as possible, and a closing question ‘How do you feel about being interviewed today?’, thus offering the interviewee options to explore any contentious issues that had arisen during the interview (Appendix 1: Protocol for Research Subject (Patient/Client) Interview Schedule; Appendix 2: Protocol for Research Subject (Homeopathic Practitioner) Interview Schedule).

¹⁰ Using an imposed frame of reference, ‘etic’, and working within the conceptual framework of those studied, ‘emic’.

It was imperative to facilitate the interviewees to move as comfortably as possible into and out of the topic, settling potentially unresolved issues that surfaced during the exchange (Foddy 1995). The questions from the interview schedule were not asked in a systematic numerical fashion but integrated tentatively into the interaction as the interviewees touched upon specific topics. Periodically, the question as exactly printed in the interview schedule was deviated from. This depended on a number of factors, including how the interviewee phrased the preceding question, how it could comfortably be integrated, and the appropriateness of the request at that precise time (Arminen 1998).

As I have experience as a practitioner, there was a further obligation regarding a code of conduct for aspects of good practice and maintaining professionally supportive relationships. This was particularly relevant with patients who were found to share intimate health concerns as a response to the question ‘Are there any aspects of the consultation process that you think weren’t very helpful?’ QV responded with ‘I went through major surgery... which meant that my progression onto other ehh (.) chemotherapy was quicker’. Potentially, this area required sensitive appropriate negotiation skills. The benefit of having experience as a statutory registered health-care practitioner, but in the role of a practitioner-researcher, is that it helped maintain the focus and purpose of the immediate research interview context. Issues similar to this were discussed previously by Kvale (1996) and Labov and Waletzky (1997), where they acknowledged similar areas of tension. Moreover, privacy issues involving balancing risks and evaluating the potential benefits to the study are ethical dimensions that merit an ongoing assessment. There is no doubt that the ethical dimensions—with regards to the precise activities of the participants’ participation—

being made clear before commencing the data collection is an effective way of maintaining the focus of the research interview (British Psychological Society 2000).

11.2.3 Practitioners' Experiences of the Research Interview

Significantly, it should be noted that, on a reflexive point, practitioners described the interview experience by responding to the question 'what feelings did you get from being interviewed today?' DH and MC respectively stated, 'Well I've never been interviewed before like this' and MC broadened the assessment by shedding light on the attentions paid to his practices during the interview. He emphasised various points: 'It was very helpful in a way to concentrate on various aspects you put to me about my practice and my feelings about homeopathy, because although I used to lecture a lot on homeopathy I've never been asked in depth about homeopathy'. This demonstrates the merits of a carefully synthesised interview schedule in which the practitioner-researcher can manoeuvre flexibly with the participants' orientations and concerns. A selection of practitioners expressed treating the interview as an education experience. Some requested copies of the audio-taped interaction—presumably to analyse the interaction—while others stated that they enjoyed the apparent challenge of being asked about their homeopathic practices.

On the downside, as a practitioner-researcher I am already immersed in the homeopathic theoretical and methodological organisational structures. As such, I have prior assumptions arising from being an actor in the topic and process being examined. A further disadvantage recognised as an insider issue is that as such I may have preconceptions and solutions in relation to the currently hotly debated issues.

Among the core objections concerning this level of knowledge, the practitioner-researcher may deliberately or unintentionally search for and present the participants with questions and loaded probes to co-construct potential solutions. On those occasions, the practitioner-researcher may push his/her own bias agendas and self-interest to produce a specific outcome or conclusion. By having knowledge of these types of issues, I reflected on each individual interview. This process assisted me in obtaining a non-directive approach—although I did uncover some potential contaminants in the way that I knew how to explore intricate homeopathic concepts. Overall, by reflecting, I worked to reduce and minimise my intrusiveness in this way. My primary aim was to build rapport by displaying empathetic techniques such as not to be intimidating by imposing solely my homeopathic knowledgebase on to the interaction. However, having homeopathic knowledge makes the interaction perhaps theoretically more interesting in interactional terms.

Another issue is that the participants themselves may view the practitioner-researcher as one with knowledge and gloss their responses to certain ‘obvious’ questions. On one occasion, the practitioner D explicitly offered a response claiming that I should know, thus demonstrating the taken-for-granted aspects to the practitioner-researcher role in the research interview setting. Taking all of the above disputes on board, unless recognised and carefully acknowledged these factors can contribute and lead to ethical dilemmas. Questions arise about how much the research interview is a reflection of the interviewees or the practitioner-researchers. This approach to the research is noted in similar practitioner-researcher contexts. Again, the onus is on the practitioner-researcher to make his or her biases evident by working across traditional boundaries to fit the ‘uniqueness’ of the situation (Meyer 2000).

Considering all the inconsistencies, in my experience the semi-structured interview is an area to be approached with considerable trepidation. Despite the constraints of the research interview, overall the interview interaction in this study proved to be absorbing and informative, providing a rich and diverse source for productive analysis. I found that not to anticipate the quality of the data or responses from the participants was one way to approach the qualitative data collection process. On completion of the research, all participants will receive a 1000 word executive summary of the research findings. This report has three main aims. First, it will show how the participants make sense of homeopathic practices in talk. Second, the report is a starting point for raising awareness about the status of homeopathy in relation to the wider medical market. In particular, the findings will show how specific strategies oriented to and invoked by participants to defend and justify their individual credibility have a potentially disempowering effect—to potentially and continually marginalise homeopathy in terms of mainstream acceptance. Third, it will focus on the potential benefits of the findings to users of homeopathy, policymakers, the theoretical and methodological contribution to DA literature, the educational and training potentials for practitioners, and future research in homeopathy, CAM and in parallel health-related contexts.

11.3 Implications of the Study

The research has important theoretical, methodological, education and policy, interdisciplinary and practical implications for a wide range of academic and non-academic beneficiaries.

11.3.1 Theoretical and Methodological Implications

This was the first study of participants' discourse of homeopathy from three data sets. On a theoretical and methodological level, by applying this innovative and integrated DA framework, my study has several contributions to make.

First, it is of theoretical use to academics and social researchers studying how participants manage the personal credibility of their practice and illustrates how homeopathy as an 'alternative' comes to be located in a culture of scepticism as a contested and controversial knowledge claim on the margins of notions of mainstream medical practices and acceptance, and not regarded as a statutory registered discipline in its own right. On those terms, my work here fills a gap in the DA literature.

This innovative study is the first to examine social constructions concerned with homeopathic practice with such a wide range of participants. Prior qualitative studies tended to focus solely on practitioners' views of homeopathy where homeopathy is referred to as either as 'complementary' or 'alternative' medicine. Here the focus is on talk and the broader discourse in the context of homeopathy as a social practice and as the topic of investigation in its own right. Therefore, by applying DA, the findings have shown that the analytical method and procedures obeyed various criteria in accordance with the theoretical perspective (Wetherell 1998), demonstrating the analysis as rigorous and credible, rather than idiosyncratic or subjective. The findings have provided an alternative perspective on the action themes present in the data on homeopathy, creating a valuable theoretical contribution to the topic of homeopathy as an action-orientated discursive practice.

Second, by applying a specific discursive framework and utilising an innovative methodology (Wetherell 1998; Edwards and Potter 1992) combining a

‘top-down’ and ‘bottom-up’ approach, the findings show that there is a wider cultural scepticism about the validity of homeopathic treatment, seen as a central issue to the participants’ mutually intelligible sense-making practices. Thus, the findings illustrate how potentially disempowering ways of talking are carried out in various contexts (the research interview/homeopathic consultation), and offer informative insights and fruitful ways of investigating other similarly contested and controversial health-related practices.

The combined DA framework showed how the findings provided novel insights into the issues of credibility at stake during everyday verbal interactions where the participants accounted for their homeopathic practices. Indeed the analysis showed how homeopathic practitioners and their patients orient to the difficulties involved in making homeopathic practice credible. The focus was on how participants use discursive resources, talk, discourse and continuing patterns observed in the strategies to defend, criticise, and justify their practices with particular effects. By asking the ‘how’ question, the findings show how, through constrained verbal interaction, participants’ orientations make their explanations credible over broad discursive strategies, corresponding to and consistent with previous discursively informed studies (Kurz *et al* 2005; Horton-Salway 2001; Wooffitt 1992). This finding makes a relevant methodological contribution to the DA literature by providing a discursive space to explicate the interactive actions performed in other contested, controversial and new medical encounters.

Third, verbal interaction is viewed as a site of social action where the participants accomplish the ‘doing’ of particular events, situations and experiences. Therefore, the analysis of the discursive devices, talk and discourses of homeopathy as realised in interviews and consultations with practitioners and patients allows us to

explore the bottom-up situated understandings of the status of homeopathy, which in turn reflect wider societal positions and sensitive discursive constructions. The various discursive devices deployed in this study are in accordance with previous discursive studies in the field (Edwards and Potter 1992; Wetherell 1998), demonstrating a cross-topic relevance by explicating how participants consistently rely on specific devices to get things ‘done’ in verbal-interactional settings. The method of analysis shows how participants deploy such devices to enhance their personal credibility and attend to the accountability of what is being said, in contrast to accurate descriptions of cognitions. This produced new insights into the contentions and controversies related to making homeopathic practices credible for these participants and highlighted the difficulties and concerns for homeopathic practice’s broader contexts.

Finally, the study, on a methodological level, contributed to DA literature through highlighting the significance of analysing in detail what participants themselves make relevant through talk, the notions they thereby attend to, and how all these factors are influenced by the immediate interactional environment, including the significant role and questions asked by the researcher. In doing so, I demonstrate a particular theoretical perspective encapsulating a broad discursive psychology framework—informed by Wetherell’s (1998) analytical framework—that generated originality for DA by offering a portrayal of the action-oriented joint construction of homeopathic practice constructed in verbal interaction sequences (Edwards and Potter 1992) which in turn reflect wider societal positions and discursive constructions that are generically relevant to a wide range of medical practices..

11.3.2 Education and Policy

My findings are also relevant for the practitioners of the Faculty of Homeopathy involved in the design and delivery of homeopathic treatment. The Faculty is involved with the day-to-day concerns and issues of all the constituent professionals. There are no qualitative studies that offer a detailed analysis of such an original data set, which is useful for developing practice and education from both a ‘bottom-up’ and a ‘top-down’ perspective.

First, one finding suggests that practitioners manage their communicative competence by aligning their practice with medicine, and that attempting to boost the credibility of homeopathy serves to downgrade homeopathy as an alternative to notions of mainstream medicine. In the process, homeopathy is presented as a contested and controversial practice.

This finding has significant relevance for those involved in the design and delivery of medical treatment. As the analysis is technically neutral about the efficacy of homeopathy, and by perhaps asking in future research ‘How do the practices of CAM practitioners work to allow them to do their job in the context of a broadly sceptical scientific and medical culture?’ the findings offer broader, general dimensions of language practices in contested medical encounters. Therefore, the finding will inform training opportunities and may be applicable to a range of alternative, contested or controversial medical encounters. By reflecting on the language practices of medical encounters, the information would provide a valuable clinical practice development training and educational resource, to develop theories and practices of interpersonal skills, explaining what participants are ‘doing’ in patient-centred—whole person—styles of communication.

Similarly, with the patients' data: through their talk, they make explicit references to the criticisms-of-medicine-to-justify-homeopathy by highlighting the potential failures of conventional medicine as a credible justification and basis for looking to homeopathy. They also talk up homeopathy as a 'last-resort-form' and 'alternative' type of practice. Accounted for in this way, both strategies serve to inform us of the ways in which specific discursive constructions and patterning position homeopathy on the margins of the medical market in a culture of scepticism.

In data drawn from the homeopathic consultations, participants demonstrate the discursive resources available by deploying three broad strategies: criticisms-of-medicine-to-justify-homeopathy, boosting-the-credibility-of-homeopathy and managing-homeopathy-as-alternative. In line with all previous findings, they show how the participants' strategies work to potentially and continually marginalise homeopathy in terms of mainstream acceptance. In so doing, homeopathy is viewed as a contested and controversial practice, not established as a discipline in its own right.

This explication can be used for training and education purposes. Here, DA can be used reflexively as a form of reflective practice for practitioners. By reflecting on the interviews and/or homeopathic consultations, a copy of specific discursive procedures, and mutually intelligible accounting practices, extracts from transcripts would provide a valuable training resource. Practitioners could be encouraged to critically examine how their talk is constructed and look to the immediate contextual effects of the mutually intelligible use of talk and the wider effects of discourse that involve specific ways of accounting through potentially disempowering constructions. If, in their talk, practitioners are viewed as potentially marginalising their practice through the reflective process, potential contrasting strategies and new ways of accounting could be explored. Certainly, issues in relation to this notion can be explored, debated and utilised further by practitioners themselves to develop progressive interactive micro-strategies in verbal medical encounters.

In addition, by proposing this, the findings would allow practitioners to understand the kinds of discursive resources made available in their social practices in relation to constructions of homeopathy. This would have the potential to empower and enable practitioners to develop broader macro-strategies to establish homeopathy as a discipline in its own right when debating and implementing future policies. Furthermore, training could be developed to facilitate a step-by-step explication that could also be utilised to prompt a discussion on both formal and non-formal 'institutional' settings. Future data could be digitalised from MP3 on to a compact disc, accompanied with a transcript for training and education purposes (Potter and Hepburn 2005).

Second, the executive summary of the PhD findings will be made available to the practitioners of the Faculty of Homeopathy and the Society of Homeopaths, as a

way of collaborating and engaging with policy makers and service design delivery specialists—for instance, in the Department of Health and the European Committee for Homeopathy political subcommittee, to influence policy and guidance initiatives in setting standards of clinical governance. The goal of the executive summary is to enhance and expand integrative interdisciplinary methods of practice on medical encounters, making a significant impact in influencing good practice initiatives. The communication of these initiatives to a broader European Union (EU) context will positively influence health service users' experiences internationally.

Moreover, in collaboration with the main institutes in the field, the findings presented in an executive summary may have implications for promoting and informing policy on single statutory register for the U.K. homeopath/CAM practitioner. This in effect would raise the profile of homeopathic practice, the status of the homeopathic practitioner and simultaneously promote, inform and influence other member states within the European Union regarding the possibilities of homeopathy.

Third, further links to the service user community will be made by dissemination of the executive summary through a wide range of NHS hospitals, health centres and the private health care sector. Many practitioners, who acted as gatekeepers in this study, expressed an interest in such a strategy and are willing to act as intermediaries. This is a significant form of dissemination, a way of reaching the general public, who may be misinformed or receiving out-of-date information regarding homeopathic practices. The findings will provide up-to-date and easy-to-understand information about the kind of issues and challenges that service users of homeopathy described when looking to homeopathy.

By way of final comment, one of the potential benefits of highlighting such potentially contentious information is to aim for the status of a statutory regulated homeopathic profession.

11.3.3 The Limitations of the Study

A number of areas demonstrate a potential limitation of this study. For instance, a notable limitation is not examining homeopathic practices in the context of other CAM therapies. Another important area would be to explore practitioners' and patients' professional and lay versions and constructions of homeopathy in contrast to CAM in general. As my study demonstrates, homeopathy is one of the most contested and controversial forms of medical treatment. In the context of CAM, there has been criticism about how the conventional scientific community has addressed homeopathy and CAM treatments as homogeneous groups. In this controversial vacuum, homeopathy as a treatment option is likely to evoke a spectrum of responses ranging from acceptance to deep scepticism. Though heralded as a therapeutic method in its own right, homeopathy would be ideal to study in a contrasting CAM context. By explicating this perspective, the findings may shed light on the complexity of aligning homeopathy as a CAM, thus offering further insights into the problematic nature of homeopathy and other CAMs' potential troubles in developing as disciplines in their own right. On the downside of conducting such a study, I would have to consider what CAM therapies to contrast with and what CAM therapies to exclude, which may present theoretical, methodological and logistical difficulties. By paying careful attention, if homeopathy is being considered and aligned within a taken-for-granted CAM framework, it may be viewed as perpetuating and accepting homeopathy in this

potentially marginalised form at the outset of data collection. Therefore, one of the core objections is that homeopathy is not examined as a discipline or practice in its own right; rather, it once more revolves around the somewhat woolly distinction between diverse CAMs.

Second, following this thinking, it would be informative to analyse interaction in over-the-counter (OTC) CAM and homeopathic medicines, where again various CAM and homeopathic medicines are often mistaken as a homogeneous grouping. In doing so, I could examine several perspectives during analysis and ask particular questions of the data, such as ‘what is this participant doing in their response?’ and ‘why this utterance/phrase/action here?’, and make use of findings regarding the discursive devices and the functions they serve. This approach may show which conditions and ailments are being talked about in relation to OTC homeopathy—including other OTC and CAMs—and how people make sense of such information as an activity sequence. Moreover, this information can be referred to as a basis for looking to develop an understanding of OTC homeopathic practices—and other CAMs. However, the privacy aspects, gaining uncoerced informed consent, and the challenge of recording such interactions maybe discouraging factors.

Third, a further limitation concerning the data source was not to use the focus group. A focus group with practitioners could provide insights into their social practices in medical encounters, not based solely on research questions. Focus group talk offers a possible ‘halfway house’ between interviews and naturally occurring data sets (Edwards and Stokoe 2004). The findings could potentially offer a flexible and novel way to establish topics of relevance made through the ordinary activities that the practitioners oriented to, reflective of the usual accounting practices (Edwards and Stokoe 2004). On the downside, there are limitations to the authenticity of this kind of

data as reflected in the constraints and expectations of the focus-group setting (Potter 2004). Moreover, the talk tends to represent anecdotal talk and talk in relation to prior experiences, situations and events in other locations. In acquiring this kind of interaction, there are issues with logistics and the availability of appropriate participants.

The absence of data from these contexts possibly leaves the findings and conclusions in this study partially limited, but offers great potential for future areas of research.

11.3.4 Future Research Directions

In a similar vein, and in the light of the findings from this study illustrating broad discursive strategies, one aspect that might require further investigation and could open possibilities for future research is in the context of the consultative process or the homeopathic medical encounter. The limited size of the homeopathic consultation data set suggests that this area could merit a future research direction. First of all, a more finely grained examination detailing the specific practices and sequential organisation of talk between homeopath and patient would elucidate how particular normative orientations are managed towards rights and responsibilities in everyday institutional interaction. Again, developing such an analysis should not be led by prior theoretical assumptions about homeopathic practices. In understanding those practices, the findings would allow a follow-up of the possible consequences of their use based on the content or design of utterances with reference to the kinds of words, phrases or examples used or actions performed.

Second, this naturally occurring data-source—from the context of formal institutional talk—uninterrupted by the researcher would be useful in studying talk, social structures and communication strategies in the homeopathic consultation by viewing what the participants treat as relevant in co-constructing their professional relationship (Edwards and Potter 2003). In relation to the notion of the uninterrupted researcher, I draw on Potter (2002) and Potter and Hepburn's (2007) view of the 'dead psychologist test', whereby the research activities would be generated irrespective of the researcher's involvement. The findings from this kind of data set could be applied to educational programmes for practitioner development, to develop theories of interpersonal skills, to explicate patient-centred styles in medical consultations, and to inform statutory regulation and policy makers on ways to develop the profession of homeopathy as a regulated discipline in its own right.

Third, through a comparison of various types of CAM and medical consultations, including the homeopathic consultation, the findings could offer an understanding of the dynamics in different types of health-care encounters across a broad spectrum. Consequently, it could bring to the fore the participants' specific orientations and concerns in each setting, illustrating an activity-based standpoint as a way to 'good' practice initiatives.

To summarise, in collecting data primarily from various medical encounters (consultative processes), the talk and the functions it serves offers a further portrayal of the action-oriented joint construction to explicate the organisation of medical interaction, providing a resource that can be drawn on for a variety of theoretical, methodological, policy and education purposes. As such, various medical encounters can be used as materials from which to develop empirical claims and practical interventions that are generically relevant to a wide range of medical practices. In the

form of discourse approaches to contested knowledge claims, these findings will enable the production of high-quality relevant research.

11.3.5 The Transferability of the Findings to Analogous Settings

In this present study, I argue that the participants manage their personal credibility with the wider effect of potentially marginalising homeopathy over four broad strategies: alignment-with-medicine; boosting-the-credibility-of-homeopathy; criticisms-of-medicine-to-justify-homeopathy; managing-homeopathy-as-alternative. The findings from this study offer new insights in the form of discursive approaches to contested knowledge claims. Arguably, discourse operates as a socially and culturally shared resource. Therefore, similar instances of some broader general patterns and features of participants' talk can potentially be transferable to analogous settings. In these settings, people negotiate their position as members of potentially socially marginalised groups in the field of contested and controversial knowledge claims. Therefore, from this perspective it could be useful to consider how discourse analysis can be utilised to focus the investigation into talk positioned in a culture of scepticism. In doing so, I identify two areas where the transferability of the findings of marginal to mainstream acceptance may apply and the ways in which the findings could be transferred to other settings. Therefore, language use about contested knowledge claims have the potential to be recognised in analogous contexts.

The findings have wider implications for the understanding of contested, new or controversial medical practices in the ways that conventional medicine is the taken-for-granted accepted yardstick for practice. In making this distinction, the boundaries of what is and what is not acceptable are judged on mainstream medical territory. In

this way, participants continually display the contested, new and controversial properties of their practices when making claims in a medical context.

The goal is to examine a broad range of medical encounters in similar culturally sceptical settings, for instance in the wider CAM market, over-the-counter CAM, in illnesses such as Myalgic Encephalomyelitis (ME), Chronic Fatigue Syndrome (CFS), or Attention-Deficit Hyperactivity Disorder (ADHD). To summarise, the research findings will provide accurate information on how everyday language use can contribute to the continuing sceptical views surrounding contested and controversial medical practices. By way of a solution, there is then the option to develop *new* dynamic, challenging and progressive ways of talking about a range of medical encounters. Therefore, it may be possible to generalise the theoretical analytical framework and assumptions into other social and interactional situations which will be data led by way of method of analysis which may offer ways in which specific and contested interpersonal issues are dealt with.

First, in the potentially controversial situation of ME or CFS highlighted by Horton-Salway (2001), the everyday management and the status of sufferers' illness-diagnosis is presented as problematic. Patients with ME or CFS who work to enhance their credibility vis-à-vis having a genuine illness design their accounts to counter the potential accusation of malingering. In order to avoid being considered discreditable, the nature and cause of their illnesses is attributed to physical causes. It might be interesting to explore participants' constructions of ME or CFS and explicate how sufferers' talk serves to provide and manage the contested and controversial knowledge claims in a similar fashion to the participants in this study.

Second, in the area of other CAM health-related practices, managing their personal credibility may offer insights into how language use can develop empirical

claims and make practical interventions relevant to a wide range of contested or controversial therapies and illnesses. For example, Chinese medicine, acupuncture, and herbal medicine are all in a similar political situation to homeopathy. Osteopathy and chiropractic have statutory regulation; acupuncture and herbal medicine are currently undergoing proposals for statutory regulation (The Prince's Foundation for Integrated Health 2007). Each CAM practitioner and each separate discipline has issues with credibility primarily related to evidence regarding the efficacy of each treatment. Primarily, they are presented under the umbrella of a CAM form of therapy and considered unscientific when contrasted with notions of mainstream medicine (Ernst 2002). The findings may consist of explaining the discursive procedures and practices made relevant in contested and controversial encounters. The goals will highlight how participants in a broadly sceptical scientific and medical culture manage individual credibility and their situated identities in interactional contexts.

ME or CFS and ADHD as a topic, and other CAM-related therapies, could be used as a forum to explore how the discourse analytical approach can make a general contribution to understanding the debate about how personal credibility is managed in everyday medical encounters and may offer insights into how the contested and controversial properties of specific groups is presented in talk.

I have shown how the transferability of findings gathered from a wider research audience and from making critical distinctions within each topic offer a broader focus towards a potential generalisability of the findings. By focusing on such settings, their constructions could be used as a forum to explicate how discursive perspectives can make a 'general' contribution to the understanding of the wider cultural scepticism about the validity of these kinds of treatment. The foci are to engage, communicate and have a significant impact with these interested parties in

iterative and innovate ways, demonstrating the theoretical, methodological and practical value of the potential future research.

11.4 Conclusion to the Study

This study has made an important, interdisciplinary, theoretical and methodological contribution to the DA literature on how participants manage personal credibility positioned in a culture of scepticism and offers insights into the notion of homeopathic practice's marginalisation in terms of mainstream acceptance. It has practical implications for policy, research and education in homeopathic practice. The points I make here extend the notion of controversial and contested knowledge claims and marginalisation as potentially useful to further theory, practice and research in parallel health-related contexts such as ME or CFS, ADHD and CAM therapies. Significantly, my research showed that for the very people who advocate homeopathy, managing their personal credibility is accomplished only through specific ways of accounting. Interestingly, the wider effect is to present homeopathy as an alternative troubled type of practice positioned on the fringe and in the light of the modern medical market. Under close cooperation, the main research based engaging activities have been designed to be an open valuable two-way communication process to develop and disseminate the findings to both a 'lay' and professional audiences.

Reference list

- Aabel, S., Fossheim, S., and Rise, F. 2001. 'Nuclear Magnetic Resonance (NMR) Studies of Homeopathic Solutions'. *British Homeopathic Journal*, 90 (1) pp 14-20.
- Ainsworth-Vaugh, N. 1998. *Claiming Power in Doctor-Patient Talk*. New York: Oxford University Press.
- Antaki, C., Billig, M., Edwards, D. and Potter, J. 2002. 'Discourse Analysis Means Doing Analysis: A Critique of Six Analytical Shortcomings'. [online] Available from: <http://extra.shu.ac.uk/daol/articles/v1/n1/a1/antaki2002002-01.html> [Accessed March 10, 2007].
- Arminen, I. 1998. 'Therapeutic Interaction: A study of mutual help in the Meetings of Alcoholics Anonymous'. Helsinki: Finnish Foundation for Alcoholics.
- Atkinson, P. 1995. *Medical Talk and Medical Work: The Liturgy of the Clinic*. London: Sage Publications.
- Atkinson, J.M. and Heritage, J. 1984. *Structures of Social Action: Studies in Conversation Analysis*. Cambridge: Cambridge University Press.
- Auburn, T. 2005. 'Narrative reflexivity as a repair device for discounting 'cognitive distortions' in sex offender treatment'. *Discourse & Society*, 16 (5) pp 697-718.
- Austin, J.L. 1962. *How to Do Things with Words: The William James lectures delivered at Harvard University in 1955*. Oxford: At the Clarendon Press.
- Baggot, R. 2004. *Health and Healthcare in Britain*. Basingstoke: Palgrave MacMillan.
- Barrett, M. 2001. 'Practical and ethical issues in planning research'. In: Breakwell, G.M., Hammond, S. and Fife-Schaw, C. 2nd ed. *Research Methods in Psychology*. London: Sage Publications, pp 24-49.
- Bellavite, P. 2003. 'Complexity science and homeopathy: A synthetic overview'. *Homeopathy*, 92 (4) 203-12.
- Birch, M. and Miller, T. 2005. 'Encouraging participating: Ethics and responsibilities'. In: Mauther, M., Birch, M., Jessop, J. and Millar, T. eds. *Ethics in Qualitative Research*. London: Sage Publications, pp 91-106.
- Boyd, W.H. 1989. *Introduction to Homeopathic Medicine*. 2nd ed. Bath: Bath Press.
- Breakwell, G. 2001. 'Interview methods'. In: Breakwell, G.M., Hammond, S. and Fife-Schaw, C. eds. *Research Methods in Psychology*. 2nd ed. London: Sage Publications, pp 232-253.
- Breakwell, G.M., Hammond, S. and Fife-Schaw, C. 2001. *Research Methods in Psychology*. 2nd ed. London: Sage Publications.
- Brewster O' Reilly, W. 1996. *Organon of the Medical Art by DR. Samuel Hahnemann*. Washington: Birdcage Books.
- Brien, S. Lewith, G. and Bryant, T. 2003. 'Ultramolecular homeopathy has no observable clinical effects. A randomised; double blind, placebo-controlled proving trial of Belladonna 30c'. *British Journal of Clinical Pharmacology*, 56 (5) 562-68.

- British Psychological Society. 2000. *Code of Conduct, Ethical Principles and Guidelines*, pp 1-60. [online] Available from: http://www.bps.org.uk/downloadfile.cfm?file_uuid=6D0645CC-7E96-C67F-75E2648E5580115&ext=pdf [Accessed: January 10, 2003]
- Burman, E. and Parker, I. 1993. *Discourse Analytic Research: Repertoires and Readings of Texts in Action*. London: Routledge.
- Burr, V. 1995. *An Introduction to Social Constructionism*. London: Routledge.
- Cant, L.S. and Calnan, M. 1991. 'On the margins of the medical market place? An exploratory study of alternative practitioners' perceptions'. *Sociology of Health & Illness*, 13 (1) pp 39-57.
- Cant, S. and Sharma, U. 1996. 'Demarcation and transformation within homeopathic knowledge. A strategy of professionalization'. *Social Science & Medicine*, 42 (2) pp 579-588.
- Carabine, J. 2001. 'Unmarried motherhood 1830-1990: A genealogy analysis'. In: Wetherell, M., Taylor, S. and Yates, S.J. eds. *Discourse as Data: A Guide for Analysis*. Milton Keynes: The Open University, pp 267-310.
- Casti, J. 1994. *Complexification*. New York. Harper Collins.
- Casti, J. 1996. 'The Simply Complex'. *Helix*, 1 (1) 12-19.
- Colquhoun, D. 2007. 'Science degrees without science'. *Nature*, 466 (7173) pp 373-374.
- Chatwin, J. 2002. Unpublished PhD Thesis 'Communication in the Homeopathic Consultation', University of York
- Degele, N. 2002. 'On the margins of everything: homeopathy as science, anti-science, or semi-science?' *Cardiff University*, pp 1-19.
- Degele, N. 2005. 'On the margins of everything: doing performing and staging science in homeopathy'. *Science, Technology & Human Values*, 30 (1) pp 111-136.
- Denzin, K.N. and Lincoln, S.Y. 1994. *Handbook of Qualitative Research*. London: Sage Publications.
- Di Blasi, Z. and Kleijnen, J. 2000. 'Consultations at the Glasgow Homeopathic Hospital'. *Department of Health Sciences and Clinical Evaluation, The University of York*, pp 1-14.
- Derrida, J. 1976. *Of Grammatology*. Baltimore, MD: John Hopkins University Press.
- Derrida, J. 2001. *Writing and Difference*. London: Routledge.
- Department of Health. 2001. *Research Governance Framework for Health & Social Care in Scotland & England*, pp 1-41. [online] Available from: <http://www.dh.gov.uk/assetRoot/04/01/47/57/04014757.pf>. [Accessed: July 4, 2003].
- Drew, P. and Heritage, J. 1992. *Talk at Work: Interaction in Institutional Settings*. Cambridge: Cambridge University Press.
- Drew, P. and Heritage, J. 1992a. 'Analyzing talk at work: an introduction'. In: Drew, P. and Heritage, J. eds. *Talk at Work: Interaction in Institutional Settings*. Cambridge: Cambridge University Press, pp 3-65.
- Edley, N. 2001. Analysing masculinity: Interpretative repertoires, ideological dilemmas and subject positions. In Wetherell, M. and Taylor, S. and Yates, S.J. eds. *Discourse as Data: A guide for analysis*. Milton Keynes: The Open University, pp 189-228.
- Edley, N. and Wetherell, M. 1997. 'Jockeying for Position: the construction of masculine identities' *Discourse & Society*, 8 (2) 203-217.

- Edwards, D. 2003. 'Analyzing racial discourse: the discursive psychology of mind-world relationships', pp 31-48. [online] Available from: <http://www.staff.lboro.ac.uk/%7Essde/Edwards%20-%20Analyzing%20racial%20discourse%202003.pdf> [Accessed: March 22, 2007].
- Edwards, D. 1991. 'Categories are for talking: on the cognitive and discursive bases of categorisation'. *Theory & Psychology*, 1 (14) pp 515-542.
- Edwards, D. 1997. *Discourse and Cognition*. London: Sage Publications.
- Edwards, D. and Fasulo, A. 2006. "'To be honest': Sequential uses of honesty phrases in talk-in-interaction'. *Research on Language and Social Interaction*, 39 (4) pp 343-376.
- Edwards, D. and Potter, J. 2005. 'Discursive psychology, mental states and descriptions'. pp 241-259. [online] Available from: <http://www.staff.lboro.ac.uk/~ssde/Edwards%20&%20Potter%20Mental%20states%202005.pdf> [Accessed: April 11, 2007].
- Edwards, D. and Potter, J. 1992. *Discursive Psychology*. London: Sage Publications.
- Edwards, D. and Potter, J. 1993. 'Language and causation: A discursive action model of description and attribution'. *Psychological Review* 100 (1) pp 23-41.
- Edwards, D. and Stoke, E.H. 2004. 'Discursive psychology, focus groups interviews and participants' categories', pp 499-507. [online] Available from: <http://www.staff.lboro.ac.uk/%7Essde/Edwards-Stokoe%20BJDP.pdf> [Accessed: February 17, 2007].
- Edwards, D. 2007. 'Managing Subjectivity in Talk', pp 1-16. [online] In: Hepburn, A. and Wiggins, S. eds. *Discursive Research in Practice: New Approaches to Psychology and Interaction*. Cambridge: Cambridge University Press. Available from: <http://www.staff.lboro.ac.uk/%7Essde/Edwards%20-%20Managing%20subjectivity%20H&W2006%20ms.pdf> [Accessed: March 22, 2007].
- Ernst, E. 2002. 'A systematic review of systematic reviews of homeopathy'. *British Journal of Clinical Pharmacology*, 54 (6) pp 577-582.
- Ernst, E. 2002a. 'The role of complementary and alternative medicine'. *British Medical Journal*, 321 (7269) pp 1133-1135.
- Faculty of Homeopathy. 2003. Faculty of Homeopathy Fact sheet: The use and practice of Complementary Medicine, pp 1-2. Luton.
- Foddy, W. 1995. *Constructing Questions for Interviews and Questionnaires: theory and practice in social research*. Cambridge: Cambridge University Press.
- Fontana, W. and Buss, L. 1995. 'What would happen if "the tape was played twice?"'. *National Academy of Science*, 91 (3) 757-61.
- Foucault, M. 1961 *Madness and Civilisation: A History in the Age of Reason*. London: Routledge.
- Foucault, M. 1973. *The Birth of the Clinic: An Archaeology of Medical Perception*. London: Tavistock Publications Limited.
- Foucault, M. 1970. *The Archaeology of Knowledge*. London: Tavistock Publications Limited.
- Foucault, M. 1983. *This Is Not a Pipe: with illustrations and letters by René Magritte*. London: University of California Press.
- Foucault, M. 1980. *Power/Knowledge: selected interviews and other writings 1992-1997*. New York: Prentice Hall.

- Frank, R. 2002. 'Homeopath & patient – a dyad of harmony?' *Social Science & Medicine*, 55 (6) pp 1285-1296.
- Frank, R. 2002a. 'Integrating homeopathy and biomedicine. Medical practice and knowledge among German homeopathic physicians'. *Sociology of Health & Illness*, 24 (1) pp 276-819.
- Frank, R. and Stollberg, G. 2001. 'Doctor-patient interaction in complementary medicine: homeopathy, acupuncture and Ayurveda in Germany'. Universitat Bielefeld: Germany, pp 1-7.
pp 1-7. [online] Available from
[http://www.uni-bielefeld.de/\(de\)/soz/iw/pdf/stollberg_frank_docpat.pdf](http://www.uni-bielefeld.de/(de)/soz/iw/pdf/stollberg_frank_docpat.pdf) [Accessed: February 22, 2003].
- Fulder, S. 1996. *The Handbook of Alternative and Complementary Medicine*. Oxford: Oxford University Press.
- Garfinkel, H. 1967. *Studies in Ethnomethodology*. Englewood Cliffs, NJ: Prentice Hall.
- General Medical Council. 2002. 'Research: The Role and Responsibilities for Doctors'. [online] Available from: <http://www.gmc-uk.org/guidance/current/library/research.asp> [Accessed: January 11 2007].
- Gergen, K.J. 2000. *An Invitation to Social Construction*. London: Sage Publications.
- Gergen, K.J. 2001. 'Construction in contention'. *Discourse & Society*, 11 (1) pp 419-432.
- Gergen, K.J. 2001a. 'Self-Narration in Social Life'. In: Wetherell, M., Taylor, S. and Yates, S.J. eds. *Discourse Theory and Practice: a reader*. Milton Keynes: The Open University, pp 247-260.
- Gergen, K.J. 2001b. *Social Construction in Context*. London: Sage Publications.
- Gergen, K.J. 2001c. 'Construction in Contention: Toward Consequential Resolutions'. *Theory & Psychology*, 2001 (11) pp 419-432.
- Gilbert, G.N. and Mulkay, M. 1984. *Opening Pandora's Box: a sociological analysis of scientists' discourse*. Cambridge: Cambridge University Press.
- Giles, J. 2007. 'Degrees in Homeopathy Slated as Unscientific'. *Nature*, 466 (7134) pp 352-353.
- Goffman, E. 1981. *Forms of Talk*. Oxford: Basil Blackwell.
- Griffin, C. 2007. 'Being dead and being there: research interviews, sharing hand cream and the preference for analysing 'naturally occurring data''. *Discourse Studies*, 9 (2) pp 246-269.
- Griffin, C. 2007a. 'Different visions: a rejoinder to Henwood, Potter and Hepburn'. *Discourse Studies*, 9 (2) pp 283-287
- Hepburn, A. and Potter, J. 2003. 'Discourse analytical practice'. In: Seale, C., Silverman, D., Gubrium, J. and Gobo, G. eds. *Qualitative Research Practice*. London: Sage Publications, pp 180-196.
- Heritage, J. 1984. *Garfinkel and Ethnomethodology*. Cambridge: Polity Press.
- Heritage, J. and Maynard, D. 2006. 'Introduction: Analyzing interaction between doctors and patients in primary care encounters'. In Heritage, J. and Maynard, D. 2006. *Communication in Medical Care Interaction Between Primary Care Physicians and Patients*. Cambridge: Cambridge University Press, pp 1- 21.
- Hewitt, J.P. and Stokes, R. 1975. 'Disclaimers'. *American Sociologic Review*, 40 (1) pp 1-11.
- Holloway, W. 1989. 'Gender difference and the production of subjectivity'. In: Henriques, J., Holloway, W., Urwin, C. and Walderkine, V. 1984. *Changing the Subject: psychology, social regulation and subjectivity*. London: Methuen, pp 227-263.

- Horton-Salway, M. 2001. 'Narrative identities and the management of personal accountability in talk about ME: a discursive psychology approach to illness narrative'. *Journal of Health Psychology*, 6 (2) pp 247-259.
- Horton-Salway, M. 2001a. 'The construction of ME: the discursive action model'. In: Wetherell, M., Taylor, S. and Yates, S.J. eds. *Discourse as Data: A Guide for Analysis*. Milton Keynes: The Open University, pp 147-188.
- House of Lords Select Committee on Science and Technology. 2000. *Sixth Report: Complementary and Alternative Medicine*. London: HM Stationery Office.
- Howarth, M. and Kneafsey, R. 2007. 'Getting ethics approval'. In: Long, T. and Johnson, M. eds. *Research Ethics in the Real World: issues and solutions for health and social care*. Edinburgh: Churchill Livingstone, pp 123-138.
- Howarth, M. and Kneafsey, R. 2007a. 'Research governance: an international perspective'. In: Long, T. and Johnson, M. eds. *Research Ethics in the Real World: issues and solutions for health and social care*. Edinburgh: Churchill Livingstone, pp 103-121.
- Hutchby, I and Wooffitt, R. 1998. *Conversation Analysis: principles, practices and applications*. Cambridge: Polity Press.
- Ibanez, T. 1994. 'Constructing a representation or representing a construction?' *Theory & Psychology*, 4 (3) pp 363-381.
- Jefferson, G. 1984. 'At first I thought': a normalising device for extraordinary events', *unpublished manuscript*. Katholieke Hogeschool: Tilburg.
- Jefferson, G. 1984a. 'One stepwise transition from talk about trouble to inappropriately next-positioned matters'. In: Atkinson, J.M. and Heritage, J. eds. *Structures of Social Science in Conversation Analysis*. Cambridge: Cambridge University Press, pp 192-222.
- Jefferson, G. 1990. 'List construction as a task and interactional resource'. In: Psathas, G. eds. *Interactional Competence*. Washington: University Press of America, pp 122-143.
- Jefferson, G. and Lee, J. 1992. 'The rejection of advice: managing the problematic convergence of a 'troubles telling' and a 'service encounter''. In: Drew, P. and Heritage, J. eds. *Talk at Work: Interaction in Institutional Settings*. Cambridge: Cambridge University Press, pp 192-222.
- Jeffery, R. 1979. 'Normal rubbish: deviant patients in casualty departments'. *Sociology of Health and Illness*, 1 (1) pp 90-108.
- Kaplan, B. 2001. *The Homeopathic Conversation: The Art of Taking the Case*. London: Natural Medicine Press.
- Kent, J.T. 1990. *Lectures on Homeopathic Philosophy*. Homeopathic Book Service: Sittingbourne.
- Kayne, S.B. 1997. *Homeopathic Pharmacy*. Edinburgh: Churchill Livingstone.
- Khuda-Bukhsh, A, R. and Pathak, S. 2008. 'Homeopathic drug discovery: theory update and methodological aspect'. *Expert Opinion on Drug Discovery*, 3 (8) pp 979-990.
- Kurz, T., Donaghue, N., Rapley, M. and Walker, I. 2005. 'The ways that people talk about natural resources: discursive strategies as barriers to environmentally sustainable practices'. *British Journal of Social Psychology*, 44 (4) pp 603-620.
- Kvale, S. 1996. *Interviews: An Introduction to Qualitative Research Interviewing*. Thousand Oaks, CA: Sage Publications.

- Labov, W. and Waletzky, J. 1997. 'Oral Narrative Analysis: Oral versions of personal experience'. *Journal of Narrative History*, 7 (1) pp 3-37.
- Laclau, E. and Mouffe, C. 1985. *Hegemony and the Socialist Strategy*. London: Verso.
- Laclau, E. and Mouffe, C. 1987. 'Post-Marxism without Apologies'. *New Left Review*, 1 (166) pp 79-106.
- Lancaster, T. and Vickers, A. 2000. Commentary: 'Larger trials are needed'. *British Medicine Journal*, 3 (7259) p 476.
- Lapadat, J. and Lindsay, A. 1999. 'Transcription in research and practice: from standardization of technique to interpretative positionings'. *Qualitative Inquiry*, 5 (4) pp 64-84.
- Lee, D. 1987. 'The Semantics of 'just''. *Journal of Pragmatics*, 11 (1) pp 377-398.
- Leckeridge, B. 1997. *Homeopathy in Primary Health Care*. Edinburgh: Churchill
- Lewith, G. and Aldridge, A. 1993. *Clinical Research Methodology for Complementary Therapies*. London: Houghton & Stoughton.
- Lewith, G., Breen, A., Filshie, J., Fisher, P., McIntyre, M., Mathie, R.T. and Peters, D. 2003. 'Complementary medicine: evidence base, competence to practice and regulation'. *Journal of the Royal College of Physicians*, 3 (3) pp 235-240.
- Linde, P. 1993. *Life Stories: The creation of Coherence*. New York: Oxford University Press.
- Long, T. 2007. 'How are these ethical issues to be resolved' In: Long, T. and Johnson, M. eds. *Research Ethics in the Real World: issues and solutions for health and social care*. Edinburgh: Churchill Livingstone, pp 63-83.
- Long, T. and Johnson, M. 2007. *Research Ethics in the Real World: issues and solutions for health and social care*. Edinburgh: Churchill Livingstone.
- Lynch, M. 2002. 'From Naturally Occuring Data to Naturally Organised Ordinary Activities: Comment on Speer'. *Discourse Studies*, 4 (4) pp 531-537.
- McCarthy, M. 2005. 'Critics slam draft WHO report on homeopathy'. *The Lancet*, 366 (9487) pp 705-706.
- Macbeth, D. 2001. 'On 'Reflexivity' in qualitative research: two readings, and a third'. *Qualitative Inquiry*, 7 (1) pp 35-68.
- May, C. and Sirur, D. 1998. 'Art, science and placebo: incorporating homeopathy in general practice'. *Sociology of Health & Illness*, 20 (2) pp 168-190.
- Mauther, M., Birch, M., Jessop, J. and Millar, T. 2005. *Ethics in Qualitative Research*. London: Sage Publications.
- Mercer, S. 2001. 'Enablement and the therapeutic alliance: an evaluation of the consultation at the Glasgow Homeopathic Hospital', pp 1-21. [online] Available from: http://www.adhom.com/adh_download/enablement.pdf [Accessed: February 19, 2003].
- Meyer, J. 2000. 'Qualitative research in healthcare: using qualitative methods in health-related action research', pp 1-5. [online] Available from: <http://www.bmj.com/cgi/reprint/320/7228/178> [Accessed: June 19, 2007].
- Millar, T. and Bell, L. 2005. 'Consenting to what? Issues of access, gate-keeping and 'informed' consent'. In: Mauther, M., Birch, M., Jessop, J. and Millar, T. eds. *Ethics in Qualitative Research*. London: Sage Publications, pp 53-69

- Mishler, E.G. 1991. 'Representing discourse: the rhetoric of transcription'. *Journal of Narrative and Life History*, 1 (1) pp 255-280.
- Mouffe, C. 1992. Feminism Citizenship and Radical Democratis Politics, In Butler, J. and Scott, J.W. eds. *Feminism Theorize and Political*. NewYork: Routlage, pp 369-85.
- Nessa, J. and Malterud, K. 1998. 'Tell me what's wrong with me: a discourse analysis approach to the concept of patient autonomy'. *Journal of Medical Ethics*, 24 (8) pp 394-400.
- Parker, I. 1992. *Discourse Dynamics: critical analysis for social and individual psychology*. London: Routledge.
- Parker, I. 2003. Discourse resources in the Unit. Discourse Analysis Online, vol. 1. no. 1. [online] Available from: <http://www.shu.ac.uk.daol/previous/v1/n1/index.htm> [Accessed: February 22, 2007].
- Pollner, M. 1987. *Mundane Reason: reality in everyday and sociological discourse*. Cambridge: Cambridge University Press.
- Pomerantz, A.M. 1984. 'Agreeing and disagreeing with assessments: some features of preferred/dispreferred turn shapes'. In: Atkinson, J.M. and Heritage, J. eds. *Structures of Social Science in Conversation Analysis*. Cambridge: Cambridge University Press, pp 57-101.
- Pomerantz, A.M. 1986. 'Extreme case formulations: a new way of legitimising claims'. *Human Studies*, 9 (1) pp 219-30.
- Potter, J. 2004. 'Discourse Analysis'. In: Hardy, M. and Bryman, A. eds. *Handbook of Data analysis*. London: Sage Publications, pp 607-624.
- Potter, J. 1996. 'Discourse analysis and constructionist approaches: theoretical background'. In: Richardson, J.T.E. eds. *Handbook of Qualitative Research Methods for Psychology and the Social Sciences*. Leicester: British Psychological Society, pp 125-140
- Potter, J. 1996a. *Representing Reality: Discourse, Rhetoric and Social Construction*. London: Sage Publications.
- Potter, J. 1997. 'Discourse analysis as a way of analysing naturally occurring talk'. In: Silverman, D. eds. *Qualitative Research: Theory, Method and Practice*. London. Sage Publications, pp 144-160.
- Potter, J. and Hepburn, A. 2005. 'Discursive psychology as a qualitative approach for analysing interaction in medical settings'. *Medical Education*, 39 (3) pp 338-344.
- Potter, J. and Hepburn, A. 2007. 'Life is out there: a comment on Griffin'. *Discourse Studies*, 9 (2) pp 276-282.
- Potter, J. and Wetherell, M. 1987. *Discourse and Social Psychology: Beyond Attitudes and Behaviour*. London: Sage Publications.
- Rapley, M. 2004. *The social construction of intellectual disability*. Cambridge: Cambridge University Press.
- Reilly, D.T. 2006. 'Evidence for Homeopathy', pp 1-20. [online] Available from: http://www.adhom.com/adh_download/EVIDENCE_9.0_Sept_06.pdf [Accessed: May 17, 2007].
- Reilly, D.T. and Taylor, M.A. 1985. 'Is Homeopathy a Placebo Response? A Proposed Study with Initial Findings Using Homeopathically Prepared Pollens in Hayfever'. *The British Homeopathic Journal*, 74 (2) pp 65-74.

- Reilly, D.T., Taylor, M.A., Beattie, N.G., Campbell, J.H., McSherry, C. and Aitchison, T.C. 1986. 'Is Homeopathy a Placebo Response? Controlled Trial of Homeopathic Potency, with Pollen in Hayfever as a Model'. *Lancet*, 2 (8521) pp 881-886.
- Reilly, D.T., Taylor, M.A., Beattie, N.G., Campbell, J.H., McSherry, C., Aitchison, T.C., Carter, R. and Stevenson, R. 1994. Is Evidence for Homeopathy Reproducible? *Lancet*, 344 (8937) pp 1601-1.
- Rogers, C. 1983. *Freedom to Learn*. London: Constable.
- Ruusuvuori, J. 2005. 'Empathy' and 'Sympathy' in action: attending to patients' troubles in Finnish homeopathic and general practice consultations'. *Social Psychology Quarterly*, 68 (3) pp 204-222.
- Sacks, H. 1992. *Lectures on Conversation Analysis Vol's I and II*. Edited by Jefferson, G. Oxford: Basil Blackwell.
- Sacks, H. (1972). On the analyzability of stories by children In Gumperz, J.J. and Hymes, D. eds. *Directions in sociolinguistics: The ethnography of communication*. New York: Rinehart & Winston, pp 222-338.
- Schegloff, E. A. (1992). In another context. In Duranti, A. and Goodwin, C. eds. *Rethinking Context: Language as an Interactive Phenomenon*. Cambridge: Cambridge University Press, pp 111-204.
- Schegloff, E. A. (1991). Reflections on talk and social structure. In Boden, D. and Zimmerman, D. eds. *Talk and social structure*. Cambridge: Cambridge Press, pp 44-70.
- Schegloff, E. A. (2007). *Sequence Organization in Interaction: A Primer in Conversation Analysis, Volume 1*. Cambridge: Cambridge University Press.
- Schegloff, E.A. 1997. 'Whose text? Whose context?' *Discourse & Society*, 8 (2) pp 165-187.
- Schroyens, J. 1996. *Synthesis Repertorium Homeopathicum Syntheticum*. Edition 8:1. Homeopathic Book Publishers: London.
- Seymour-Smith, S., Wetherell, M. and Phoenix, A. 2002. 'My wife ordered me to come!': a discursive analysis of doctors' and nurses' accounts of men's use of general practitioners'. *Journal of Health Psychology*, 7 (3) pp 253-267.
- Shang, A., Huwiler-Müntener, K., Nartey, L., Jüni, P., Dörig, S., Sterne, J.A.C., Pewsner, P. and Egger, M. 2005. 'Are the clinical effects of homeopathy placebo effects? Comparative study of placebo-controlled trials of homeopathy and allopathy'. *Lancet*, 366 (9487) pp 726-732.
- Shapiro, M. 1992. *Reading the Postmodern Polity: political theory as textual practice*. Minneapolis: University of Minnesota Press.
- Shekelle, P.G., Morton, S.C., Suttrop, M.J., Buscemi, N. and Friesen, C. 2005. 'Challenges in Systematic Reviews of Complementary and Alternative Medicine Topics'. *Annals of Internal Medicine*, 142 (12) pp 1042-1047.
- Silverman, D. 1997. *Qualitative Research: Theory, Method and Practice*. London: Sage Publications.
- Silverman, D. 2001. *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction*. 2nd ed. London: Sage Publications.
- Silverman, D. 2002. *Doing Qualitative Research: A Practical Handbook*. 2nd ed. London: Sage Publications.
- Skraabane, V. 1986. 'Demarcation of the Absurd'. *Lancet*, 6 (4) 960-2.
- Smith, G. 2003. 'Homeopathy'. *Triple Helix*. Summer, pp 5-7. [online] Available from: <http://admin.cmf.org.uk/pdf/helix/sum03/24homeopathy.pdf> [Accessed: November 15, 2003].

- Smith, J.A. 1995. 'Semi-structured interviewing and qualitative analysis'. In: Smith, J.A., Harré, R. and Van Langenhove, L. eds. *Rethinking Methods in Psychology*. London: Sage Publications, pp 9-26.
- Skraabanek, V. 1986. 'Demarcation of the Absurd'. *Lancet*, 6 (1012) pp 960-962.
- Society of Homeopathy. 2004. Annual Review 2004, pp 1-23. [online] Available from: <http://www.homeopathy-soh.org/about-the-society/downloads/Annual%20Review%202004.pdf> [Accessed: July 27 2004].
- Society of Homeopathy. 2004a. Code of Ethics and Practice, pp 1-25. [online] Available from: <http://www.homeopathy-soh.org/for-homeopaths/documents/CodeofEthicsApr04.pdf> [Accessed: January 11, 2007].
- Speer, A.S. 2002. 'Natural' and 'Contrived' data: a sustainable distinction?' *Discourse Studies*, 4 (4) pp 511-525.
- Stoke, L. and Hepburn, A. 2005. 'You can hear a lot through the walls': Noise formulations in neighbour complaints.' *Discourse & Society*, 16 (5) 647-673.
- Stiles, W.B. 1996. 'Stability of the verbal exchange structure of medical consultations'. *Psychology and Health*, 11 (12) pp 773-785.
- Strauss, A. and Corbin, J. 1994. Grounded theory methodology. In Denzin, N.K. and Lincoln, Y.S. eds. *Handbook of qualitative research*. London: Sage Publications. pp 273-285.
- Swayne, J. 1998. *Homeopathic Method: Implications for Clinical Practice and Medical Science*. Edinburgh: Churchill Livingstone.
- Swayne, J. 2000. *International Dictionary of Homeopathy*. Edinburgh: Churchill Livingstone.
- Taylor, S. 2001. 'Evaluating and applying discourse analytic research'. In: Wetherell, M., Taylor, S. and Yates, S.J. eds. *Discourse as Data: a guide for analysis*. Milton Keynes: The Open University, pp 310-330.
- Taylor, M.A., Reilly, D., Llewellyn-Jones, R., McSharry, C. and Atchinson, T.C. 2000. 'Randomised Controlled Trial of Homeopathy Versus Placebo in Perennial Allergic Rhinitis with Overview of Four Trial Series'. *British Medical Journal*, 2 (321) pp 471-476.
- The Lancet. 2005. 'Editorial: The end of homeopathy. *Lancet*, 366 (9487) 690.
- The Prince's Foundation for Integrated Health. 2007. Regulation of Complementary Healthcare. [online] Available from: <http://www.fih.org.uk/aboutus/Regulation/reggroups.htm> [Accessed: March 16, 2007].
- Tilley, S. 2003. 'Challenging' Research practices: Turning a critical lens on the work of transcription'. *Qualitative Inquiry*, 9 (5) pp 750-773.
- Vandenbrouke, J.P. 2005. 'Homeopathy and "the growth of truth"'. *Lancet*, 366 994870 691-92.
- Vandenbrouke, J.P. 1997. 'Homeopathy Trials: Going Nowhere'. *Lancet*, 350 (4) 824-5.
- Vermeulen, F. 1994 *Concordant Materia Medica*. Emrys by Publishers: Netherlands.
- Walach, H., Lewith, G.T. and Jonas, W.B. 2002. 'The role of outcome research in evaluating complementary and alternative medicine'. *Alternative & Complementary Medicine*, 8 (2) pp 88-95.
- Watson, D.R. and Weinberg, T.S. 1982. 'Interviews and the interactional construction of accounts of homosexual identity'. *Social Analysis*, 11 (1) pp 56-78.

- Wetherell, M. 2001. 'Debates in discourse research'. In: Wetherell, M., Taylor, M. and Yates, S.J. eds. *Discourse Theory and Practice: A Reader*. Milton Keynes: The Open University, pp 380-399.
- Wetherell, M., Taylor, S. and Yates, S.J. 2001. *Discourse as Data: A Guide for Analysing*. London: Sage Publications.
- Wetherell, M. Taylor, S. and Yates, S.J. 2001a. *Discourse Theory and practice: A Reader*. London: Sage Publications.
- Wetherell, M. 1998. 'Positioning and interpretative repertoires: conversation analysis and post-structuralism in dialogue'. *Discourse & Society*, 9 (3) pp 387-412.
- Wetherell, M. 2005. 'Unconscious conflict or everyday accountability?' *British Journal of Social Psychology*, 44 (2) pp 169-173.
- Widdicombe, S. and Wooffit, R. 1995. *The Language of Youth Subcultures: Social Identity in Action*. Hemel Hempstead: Harvest Wheatsheaf.
- Wittgenstein, L. 1953. *Philosophical Investigations*. Oxford: Basil Blackwell.
- Wooffitt, R. 2001. 'Researching psychic practitioners: conversation analysis'. In: Wetherell, M., Taylor, S. and Yates, S.J. eds. *Discourse as data: A guide for analysis*. Milton Keynes: The Open University, pp 49-92.
- Wooffitt, R. 1992. *Telling Tales of the Unexpected: the organisation of factual discourse*. Hemel Hempstead: Harvest Wheatsheaf.
- Wooffitt, R. 2005. *Conversation Analysis and Discourse Analysis: A Comparative and Critical Introduction*. London: Sage Publications.
- Yardley, L. 1996. 'Reconciling discursive and materialist perspectives on health and illness: a reconstruction of the biopsychosocial approach'. *Theory & Psychology*, 6 (3) pp 485-508.
- Yates, S.J. 2004. *Doing social science research*. London: Sage Publications.
- Youssef, V. and Silverman, D. 1992. 'Normative expectations for medical talk'. *Language and Communication*, 12 (2) pp 123-131.
- Zollerman, C. and Vickers, A. 1999. 'ABC of complementary medicine: What is complementary medicine?' *British Medical Journal*, 319 (7211) pp 693-696.

Multi-Centre Research Ethics Committee Response Form and Letter of Approval Document

RESPONSE FORM

Chairman: Professor P Peattie Vice-Chairman: Mr P Rogers

DETAILS OF APPLICANT:

1. Name and address of Principal Researcher:

Mr Craig Thomas Campbell
6 Oxford Terrace
Edinburgh
EH4 1PX

2. Title of project:

An exploratory study of discourses of homeopathy and their effects.

3. Name and address of Sponsor:

N/A

DETAILS OF MREC:

4. MREC for Scotland

Deaconess House
148 Pleasance
Edinburgh
EH8 9RS

5. MREC Reference Number: MREC/03/10/89

6. Listed below is a complete record of the review undertaken by the Committee with the decisions made, dates of decisions and the requirements at each stage of the review:

Date of review: 13 November 2003

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Committee members in attendance:

Professor P Peattie(Nurse) (Chairman)
Mr P Rogers (Consultant Surgeon)
Dr K Beard (Consultant Physician)
Dr M Booth (Consultant Anaesthetist)
Mr A C Fraser (Lay)
Dr B Holland (Consultant Paediatrician)
Mrs H Millar (Lay)
Mrs J Munro (Allied Health Professions)
Dr J Robins (Consultant Obstetrician/Gynaecologist)
Mr I Smith (Lay)

Mrs F Campbell (Statistician)
Professor C Bond (Consultant in Pharmaceutical Public Health)
Dr I McKee (General Practitioner)
Dr R Pearsall (General Practitioner)
Mrs F Phab (Statistician)

Outcome of review: Approved Subject to Changes

Documents reviewed:

MREC Application Form signed on the 23rd October 2003
Research Subject Information Sheet Version 1 dated October 2003*
Advertisement for Research Version 1 dated October 2003*
Information Sheet Version 1 dated October 2003*
Research Subject (Patient) Interview Schedule Version 1 dated October 2003*
Research Subject (Homeopathic Practitioner) Interview Schedule Version 1 dated October 2003*
Invitation Letter to Patient Version 1 dated October 2003*
Invitation Letter to Homeopathic Practitioner Version 1 dated October 2003*
Research Consent and Confidentiality Statement Version 1 dated October 2003*
Letter from Catherine Roberts
Curriculum Vitae
Research Protocol explanation Version 1 dated October 2003*
Research Protocol 5 Copies Version 1 dated October 2003*

- Version Number and Date given by MREC Scotland

Changes/Information requested:

1. Clarify Recruitment Process as it is unclear how subjects are selected
2. Clarify if practitioners are NHS, private or both
3. Why are GPs being involved? Is it only GPs practising homeopathy or if a patient is recruited through a private homeopathic clinic will a request for information be made to the patient's GP?
4. The GP or managing clinician must have the participant's consent before disclosing their name to the researcher
5. Clarify who would be initially approaching the subject. Why does the letter to the patient include a copy of the advert?
6. Why does the letter to the practitioner say "If you have any objections to your patient taking part..." The following sentence does not make sense?
7. Give an assurance that participants would see a transcript of the tape-recording to approve and explain this in the PIS
8. Clarify the mechanism for allowing subjects to withdraw and what would happen to their completed questionnaires
9. The consent form should have its own date and version number and should mention date and version number of the participant information sheet
10. All the accompanying letters and adverts should have a date and version number
11. Clarify where the adverts to be placed?
12. Participant information sheet
 - i. Should have sub-headings
 - ii. Should break the text into more manageable sub-sections
 - iii. Should be more invitational. Invite rather than ask participants to participate. Change heading "Why have I been chosen?" to "Why have I been invited?"
 - iv. Should Use less technical language and be more user friendly e.g.

"discourses," "question guide" and "therapeutic"

- v. The participant information sheet should state that the participant will be given a copy of the consent form for retention
- vi. Should provide more information on what the study is designed to do (in user friendly language)
- vii. Should state that no reason need be given for declining
- viii. Should indicate what would happen to information already gathered if participant withdraws
- ix. Should indicate the participant is not obliged to answer every question put to them (a point which should be stressed at the commencement of the questioning)
- x. Correct typing error where "Serious" is used, but "Series" is apparently meant.

Documents reviewed by Lead Reviewers:

Letter of Response received 28 November 2003

Research Protocol explanation in 'lay' terms, Version 2 – November 2003 – Tracked

Research Protocol explanation in 'lay' terms, Version 2 – November 2003 – Clean

Research Subject Information Sheet, Version 2 – November 2003 – Tracked

Research Subject Information Sheet, Version 2 – November 2003 – Clean

Research Subject Informed Consent and Confidentiality Statement – Tracked

Research Subject Informed Consent and Confidentiality Statement – Clean

GP Information Sheet, Version 2 – November 2003 – Tracked

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GP Information Sheet, Version 2 – November 2003 – Clean

Advertisement for Research (for practitioners), Version 2 - November 2003 – Tracked

Advertisement for Research (for practitioners), Version 2 - November 2003 – Clean

Advertisement for Research (patient's), Version 2 - November 2003 – Tracked

Advertisement for Research (patient's), Version 2 - November 2003 – Clean

Patient Letter, Version 2 – November 2003 - Tracked

Patient Letter, Version 2 – November 2003 – Clean

GP Letter, Version 2 – November 2003 – Tracked

GP Letter, Version 2 – November 2003 – Clean

Date approved by Lead Reviewers: 4 December 2003

7. FINAL DOCUMENTS AND ARRANGEMENTS APPROVED BY THE MREC

The following items have been approved by the Multi-Centre Research Ethics Committee for

Scotland:

MREC Application Form signed on the 23rd October 2003

Research Subject (Patient) Interview Schedule Version 1 dated October 2003*

Research Subject (Homeopathic Practitioner) Interview Schedule Version 1 dated October 2003*

Letter from Catherine Roberts

Curriculum Vitae

Research Protocol 5 Copies Version 1 dated October 2003*

Research Protocol explanation in 'lay' terms, Version 2 – November 2003

Research Subject Information Sheet, Version 2 – November 2003
Research Subject Informed Consent and Confidentiality Statement
GP Information Sheet, Version 2 – November 2003
Advertisement for Research (for practitioners), Version 2 - November 2003
Advertisement for Research (patient's), Version 2 - November 2003
Patient Letter, Version 2 – November 2003
GP Letter, Version 2 – November 2003
Methods of initial recruitment to study
Compensation arrangements for subjects
Payments to researcher
Provision of expenses for subjects
* Version Number and Date given by MREC Scotland

CHRIS GRAHAM

MREC Administrator

Multi-Centre Research Ethics Committee for Scotland

Date: 4 December 2003

LETTER OF APPROVAL

Mr Craig Thomas Campbell
6 Oxford Terrace
Edinburgh
EH4 1PX

Date: 4 December 2003
Our Ref.: MREC/03/10/89
Enquiries to: Chris Graham
Extension: 89027
Direct Line: 0131 536 9027
Email: chris.graham@lhb.scot.nhs.uk

Dear Mr Campbell

MREC/03/10/89: An exploratory study of discourses of homeopathy and their effects.

The members of the Multi-Centre Research Ethics Committee for Scotland delegated to lead the review of this application have considered the changes submitted in response to the Committee's earlier review of your application on 13 November 2003 as set out in our letter dated 18 November 2003. The documents considered were as follows:

Letter of Response received 28 November 2003
Research Protocol explanation in 'lay' terms, Version 2 – November 2003 – Tracked
Research Protocol explanation in 'lay' terms, Version 2 – November 2003 – Clean
Research Subject Information Sheet, Version 2 – November 2003 – Tracked
Research Subject Information Sheet, Version 2 – November 2003 – Clean
Research Subject Informed Consent and Confidentiality Statement – Tracked
Research Subject Informed Consent and Confidentiality Statement – Clean
GP Information Sheet, Version 2 – November 2003 – Tracked
GP Information Sheet, Version 2 – November 2003 – Clean
Advertisement for Research (for practitioners), Version 2 - November 2003 – Tracked
Advertisement for Research (for practitioners), Version 2 - November 2003 – Clean
Advertisement for Research (patient's), Version 2 - November 2003 – Tracked
Advertisement for Research (patient's), Version 2 - November 2003 – Clean
Patient Letter, Version 2 – November 2003 - Tracked
Patient Letter, Version 2 – November 2003 – Clean
GP Letter, Version 2 – November 2003 – Tracked
GP Letter, Version 2 – November 2003 – Clean

The 'lead reviewers', acting under delegated authority, are satisfied that these accord with the decision of the Committee and have agreed that there is no objection on ethical grounds to the proposed study. I am, therefore, happy to give you the favourable opinion of the Committee on the understanding that you will follow the conditions of approval set out below. A full record of the review undertaken by the Committee is contained in the attached MREC Response Form. The project must be started within three years of the date of this letter.

Conditions of Approval

- You do not undertake this research in an NHS organisation until the relevant NHS management approval has been obtained as set out in the Framework for Research Governance for Health and Community Care (Research Governance for Health and Social Care in England).
- You do not deviate from, or make changes to, the protocol without prior written approval of the Committee, except where this is necessary to eliminate immediate hazards to research participants or when the change involves only logistical or administrative aspects of the research. In such cases the Committee should be informed within seven days of the implementation of the change.
- You complete and return the standard progress report form to the Committee one-year from the date of this letter and thereafter on an annual basis. This form should also be used to notify the Committee when your research is completed. In this case the form should be sent to the Committee within three months of completion of the research.
- If you decide to terminate this research prematurely you must send a report to the Committee within 15 days, indicating the reason for the early termination.
- You advise the Committee of any unusual or unexpected results that raise questions about the safety of the research.

Local Submissions

The study has been approved under the supplementary guidelines for processing applications where there is no local researcher. You should inform the appropriate Local Research Ethics Committees (LRECs) of the research but in this instance their approval is not necessary.

ICH GCP Compliance

The Committee is fully compliant with the International Conference on Harmonisation/Good Clinical Practice (ICH GCP) Guidelines for the Conduct of Trials Involving the Participation of Human Subjects as they relate to the responsibilities, composition, function, operations and records of an Independent Ethics Committee/Independent Review Board. To this end it undertakes to adhere as far as is consistent with its Constitution, to the relevant clauses of the ICH Harmonised Tripartite Guideline for Good Clinical Practice, adopted by the Commission of the European Union on 17 January 1997. The Standing Orders and a Statement of Compliance were included on the computer disk containing the guidelines and application form and are available on request or on the Internet at www.corec.org.uk

Yours sincerely

CHRIS GRAHAM

MREC Administrator

Table 1: Practitioners in one-to-one interviews

Practitioners in one-to-one interviews			
Pseudonym of Practitioner	Gender	Years of Experience as a Practitioner	Duration of Interview (Minutes)
NS	M	12	85
WS	M	8	60
RD	M	17	70
CW	M	11	90
MC	M	36	85
DH	M	17	80
KM	M	6	67
CD	F	19	79
BH	F	21	64
AA	F	9	85
L	F	18	90
K	F	23	68
PH	F	7	77
CO	F	27	89
YS	F	9	75
U	F	14	64
VA	F	6	66
G	F	22	74
WM	F	5	75
D	F	29	89

Table 2: Homeopathic patients/clients in one-to-one interviews

Homeopathic patients/clients in one-to-one interviews			
Pseudonym of the Patient/Client	Gender	Years of Experience with Homeopathy	Duration of Interview (Minutes)
SP	M	6	65
AM	M	12	60
TB	F	7	75
DK	F	9	66
BW	F	16	66
DW	F	4	60
X	F	6	70
JK	F	7	75
SV	F	8	68
RM	F	9	65
CL	F	3	63
TC	F	8	66
OS	F	11	76
Z	F	2	70
QV	F	10	70

Table 3: Practitioners and patient/clients in one-to-one homeopathic consultations

Practitioners and patient/clients in one-to-one homeopathic consultations						
Pseudonym of the Practitioner	Gender	Years of Experience as Practitioner	Pseudonym of Patient/Client	Gender	Years of Experience with Homeopathy	Duration of Consultation (Minutes)
DH	M	17	PP	F	0	90
			MP	M	0	90
NS	M	12	CG	F	4	90
CW	M	11	BF	F	2	55
CO	F	27	DK	F	9	65
BH	F	21	SV	F	8	90

Protocol for Research Subject (Homeopathic Practitioner) Interview Schedule

The Practitioner: Professional Qualifications

- 1 – Could you tell me something about yourself?
- 2 – How would other people describe you?
 - Why?
- 3 – What is your professional title?
 - Why?
 - How would you describe your professional role?
 - Are you a member of any professional bodies?
- 4 – What qualities are needed to become a [homeopath]?
 - Why? [other]
- 5 – What qualifications do you need to be a [homeopath]?
 - [other]
- 6 – Could you describe some of your reasons for getting interested in homeopathy?
- 7 – How do you think being a [homeopath] differs from other healthcare practitioners?
 - [other]
- 8 – What is a homeopath?

Homeopathy Principles/mechanisms

- 8 – What is homeopathy?
- 9 – How does homeopathy work?
- 10 – Is there proof that homeopathy works?
 - If yes – What proof is there?
 - If no – Why not?
- 11 – What types of research can be positive for demonstrating the homeopathic approach?
 - Why?

Homeopathic Method

- 12 – Is there a homeopathic [diagnosis]?
 - or [conclusion]

- If yes – What is it?
 - If no – Why not?
 - If no – What is there?
- 13 – What aspects of the person draw you to the homeopathic [diagnosis]?
[conclusion]?
- 14 – Is there always one correct remedy?
– Why?
- 15 – How do you find the remedy/remedies?
- 16 – Do you treat people according to Hahnemann principles and methods?
– If yes – What are they?
– If no – What methods do you use?

Treatment

- 17 – Could you explain some of the reasons on how homeopathic treatment can benefit a patient?
– Why?
- 18 – What is a symptom?
– Could you describe what it is?
- 19 – What would you treat with homeopathy?
– Why?
- 20 – What would you not treat with homeopathy?
– Why?
- 21 – How does homeopathy view an illness in the person?
– Why?

Consultation Process

- 22 – What is the homeopathic consultation?
- 23 – Could you describe some of the different ways you approach the homeopathic consultation?
- 24 – Is there such a thing as a therapeutic relationship?
– If yes – What is it? – What do you mean?
– If no – Why not?
- 25 – How much time do you spend with a patient?
– Why?

26 – What [training or life experiences] have you personally contributed to the consultation process?

Patients

27 – What expectations do you have of patients?
– Why?

28 – What expectations do patients have of homeopathy?
– Why?

29 – What reasons do patients give for using homeopathy?
– Why?

The researcher

30 – What feelings did you get from being interviewed today?
– Why?

Last

31 – What else would like to tell me about your experiences with [homeopathy]?
[other]

Protocol for Research Subject (Patient/Client) Interview Schedule

The Patient/client

- 1 – Could you tell me something about yourself?
- 2 – How would other people describe you?
 - Why?

Why homeopathy?

- 3 – Why did you choose to use homeopathy?
- 4 – How do you know about homeopathy?

The homeopathic practitioner

- 5 – What was the practitioners (professional) title?
- 6 – Why did you choose to use the [homeopath] that you used?
 - [other]
- 7 – What feelings did you get from the [homeopath]?
 - [other]
 - Why?
- 8 – What qualities do you look for in the [homeopath]?
 - [other]
 - Why?
- 9 – What sort of things do you look for in the [homeopath]/patient relationship?
 - [other]
 - Why?
- 10 – What do you think the importance is of the [homeopath/patient] relationship?
 - [other/patient]
- 11 – In what ways could the [homeopath/patient] relationship be improved?
 - [other/patient]

What does homeopathy do for you?

- 12 – What is homeopathy?
- 13 – How do you think homeopathy works?

- 14 – What do you like about homeopathy?
- 15 – What can homeopathy help you with?
– Why?
- 16 – What would you not consult a [homeopath] with?
[other]
– Why?
- 17 – Have you used a homeopathic remedy?
– If yes – In what ways do the remedy/remedies affect you?
– If no – why not?
- 18 – How would you describe a successful treatment of homeopathy?
– What are the benefits of homeopathic treatment?

Consultation Process

- 19 – What were the most important aspects of the [homeopathic] consultation process for you?
[other]
- 20 – What aspects of the [homeopathic] consultation process were not very helpful for you?
[other]
- 21 – What things made an impression, in the environment where the consultation took place?
- 22 – In what ways does the [homeopathic] process differ from other approaches in health care?
[other]
- 23 – What are your overall expectations after using [homeopathy]?
[other]

The researcher

- 24 – What feelings did you get from being interviewed today?
– Why?

Last

- 25- What else would like to tell me about your experiences of [homeopathy]?
[other]?

Transcript notation

An abbreviated version of the full transcript notation by Atkinson & Heritage (1984) was adopted for this study.

(.)	A dot in the bracket indicates an audible pause, not timed
...	material omitted
((laugh))	Words in double bracket refers to the transcribers comments on
((name of place))	features of the talk; material added or omitted to maintain anonymity and confidentiality
=	Equal sign indicates continuous talk between speakers.

Full transcription of a research interview with a practitioner

NS: the practitioner

CC: the researcher

Recording microphone switched on:

- 1 CC: could you tell me some thing about yourself
- 2 NS: yeah depending what in life (.) experience or =
- 3 CC: = yeah =
- 4 NS: = ehh (.) I'll tell you how I came to homeopathy (.) I've always been
- 5 interested in alternative things ways of living (.) eh um but not really
- 6 looked into (.) alternative medicine very much but when my son was
- 7 ehh um (.) one year old which is twenty years ago now ehh um (.) he
- 8 had constant ear infections one winter and ehh after getting normal
- 9 treatment antibiotics about three (.) ehh um (.) we just thought it's not
- 10 good enough I went to some classes in homeopathy found (.) ehh (.)
- 11 with some help from the person who was giving the classes (.) the
- 12 homeopath I found a remedy that would stop ear infections instantly
- 13 CC: = hmm mm =
- 14 NS: = took him for what's called a constitution or chronic treatment (.)
- 15 after that he had a different remedy a deeper remedy his: his chronic
- 16 remedy and he never had another ear infection!
- 17 CC: = hum =
- 18 NS: = so I got interested
- 19 CC: = yeah =
- 20 NS: = did some night classes and reading eventually went to college
- 21 CC: you mentioned something about a constitutional remedy remedy there
- 22 =
- 23 NS: = yeah
- 24 CC: = what is that
- 25 NS: well eh (.) most homeopaths (.) believe or used to believe that there is
- 26 one remedy for a person ehh (.) umm or at least (.) but especially with
- 27 young children it's probably (.) the way they came into the world ehh
- 28 mm (.) y' know any fundamental weakness that might lead to illness
- 29 later on might I think would be there from the beginning (.) so the
- 30 constitutional remedy is is (.) one that kinda strengthens them in that
- 31 way although the constitution isn't quite like (.) saying the constitution
- 32 of an ox or something like =
- 33 CC: = yeah (.) okay=
- 34 NS: = that it's more how that person is there with their strengths and
- 35 weaknesses (.) and so some times we call it the chronic remedy to save
- 36 any confusion but then there is a confusion there as well because ((in
- 37 audible)) I don't think we think about the word chronic the same way
- 38 the medical profession would the conventional medical profession (.)
- 39 ehh (.) umm a chronic disease might be ehm (.) bronchitis or arthritis
- 40 often finishing with it is (.) but ehummm tch (.) that's the name of a
- 41 disease

42 CC: yes so its
 43 NS: when we say chronic we mean the sum total of that persons weaken (.)
 44 see if you if that's accurate (.) we can find a remedy we can look for a
 45 remedy anyway that matches that so we'd (.) say that's their chronic
 46 disease which is not one named disease but it's their stuff (.) and if we
 47 match them including their character (.) through a medicine that is
 48 known then we give that medicine and we'd hope to see a strengthen
 49 of that ehh picture
 50 CC: I think (.) I'll come back to that later
 51 NS: okay
 52 CC: very interesting ehh
 53 NS: yeah
 54 CC: ehh (.) umm how would others describe your role
 55 NS: how would others describe a homeopath
 56 CC: well how would other people describe
 57 NS: oh as a person (.) eh (.) somebody called me languid recently I liked
 58 that =
 59 CC: = hmm =
 60 NS: = hmm (.) but that's just my body ehh mm probably they'd describe
 61 me as ehh thoughtful ehm (.) compassionate if I was lucky ehh (.)
 62 caring maybe ehh (.) enthusiastic I suppose
 63 CC: ehh (.) what is your professional title
 64 NS: homeopath
 65 CC: yes (.) why would your (.) call yourself a homeopath
 66 NS: because I use the system which is homeopath the word means like
 67 cures like (.) homeopathy is the law of similars applied so like cures
 68 like =
 69 CC: = yeah =
 70 NS: = homeopathos similar suffering so that's what I do
 71 CC: hmm mm (.) so how does that work then like cures like what would
 72 you
 73 NS: ehh (.) well it's almost like you have to (.) chi (.) see the person and
 74 their dis(.) es (.) ss if you like =
 75 CC: = hmm =
 76 NS: = and then find a medicine a homeopathic remedy that has the same
 77 disease (.) picture ehh (.) mm then you apply it to the person and then I
 78 think there is a cancelling out that's the way I look at it
 79 CC: ehh (.) how would you say being a homeopath differs from say other
 80 healthcare practitioners
 81 NS: ehh (.) we (.) I think probably mainly in (.) that I do ((in audible)) like
 82 cures like there's not many people gone for that that direction
 83 conventional medicine is obviously ehh umm allopathy so it's giving
 84 the opposite (.) got a fever give something that brings it down and I
 85 think in some way's herbalism might be the same tch (.) most people
 86 will be trying to counteract something were trying to go with it and the
 87 body will then counteract or what we call the vital force
 88 CC: so what is the vital force
 89 NS: It's the biggest question of all really ha
 90 CC: I don't know if we have
 91 NS: there's there's no answer to that but I think it's the same as ehh (.) tch

92 in China or Pirannha in India it's the life energy which is different
 93 from tch (.) the energy of the cells (.) it's something behind all this that
 94 (.) informs the whole body at once =
 95 CC: = hmm =
 96 NS: = keeps things ticking over and makes us different (.) the vital force a
 97 good phrase
 98 CC: right (.) so what qualities eh (.) do you think you need to become a
 99 homeopath
 100 NS: tch (.) you have to be a good listener =
 101 CC: = yeah =
 102 NS: = mm (.) and not want to join in all the time =
 103 CC: = right
 104 NS: eh (.) It's not a conversation (.) for a lot of the pract (.) the eh mm
 105 consultation
 106 CC: interesting eh mm a lot of people talk about (.) the homeopathic
 107 conversation
 108 NS: yes there's there's a non-verbal conversation
 109 CC: yeah
 110 NS: eh tch what I mean is that if something interesting come up tch you
 111 could get a conversation going on that and perhaps find out something
 112 psychological about the person whatever but I wouldn't do that tch (.)
 113 eh (.) I really like if the person comes in for the first time we kind of
 114 (.) like get used to each other and then the person talks for forty-five
 115 minutes without me doing anything except listening quite often they
 116 need some prompting (.) and some people need lots of questions but
 117 my idea is to listen and come in later and if there are things that I still
 118 need draw them out a little or the have a conversation which might be
 119 about the cinema or books or something so I think we listen
 120 CC: yeah (.) and what qualifications do you think you need to be a
 121 homeopath
 122 NS: tch (.) patience eh (.) umm the ability not to judge (.) y' know not
 123 making a judgment about a person whether that's they do that thing
 124 that's wrong =
 125 CC: = hmm =
 126 NS: = I don't like this person whatever just taking it take it on
 127 CC: what
 128 NS: do you want any other ones eh (.) qualifications eh um
 129 CC: yeah please
 130 NS: qualifications eh (.) eh =
 131 CC: = ((cough)) =
 132 NS: again compassion but not eh mm (.) tch (.) any kinda step back kinda
 133 way eh (.) if you get to involved with the terrible things that happen in
 134 peoples life's you cannot see clearly what they might need (.) eh
 135 sense of humour (.) and cos I'm not really happy unless we've had a
 136 good laugh as well you well depends who the person is =
 137 CC: = okay (.) yeah =
 138 NS: = but eh (.) if they cry as well that's all part of it (.) eh (.) some
 139 kind of relaxed concentration that's what you need I think
 140 CC: you eh (.) mentioned you were at college as well
 141 NS: mm uhm tch (.) well most of us go through the conventional in

142 homeopathic terms training ehh tch (.) I went to college in Edinburgh
 143 Glasgow and London
 144 CC: oh
 145 NS: because ehh after a year or two I heard about this particular college and
 146 decided to go to it (.) that was in London ehh you just need a teacher
 147 that suits you
 148 CC: yeah (.) could you tell me more about that college in London
 149 NS: that sort
 150 CC: that college in London what sort of things did you learn there
 151 NS: ehh (.) phew (.) well it's called the ((name of establishment)) (.) and (.)
 152 the idea of it cos I was in the first year of it when it was set up in 1990
 153 CC: right (.) okay
 154 NS: so we were the first lot through and the idea was to look at (.) what's
 155 seemed to be the principles of homeopathy and really examine them
 156 and see if they held up and if they did we'd use them and if they didn't
 157 we'd chuck them out (.) so the basics seemed to be really sound but
 158 we'd just went of (.) on a ((in audible)) and ehh in various ways to
 159 apply those and what they meant and how they connected to ehh other
 160 healing systems Chinese medicine ((in audible)) (.) ehh mm tch (.) so
 161 y' know I was hearing stuff like this so I decided to go (.) and ehh (.)
 162 well you hear this quite often it was definitely a life-changing
 163 experience getting into homeopathy (.) can be to some level but this
 164 particular way of teaching was eh (.) just right for me (.) so I still use
 165 (.) what I learned there everyday (.) with with my own variations on it
 166 CC: your own variations so you (.) you're bringing something new to
 167 homeopathy
 168 NS: tch (.) well just me
 169 CC: or hmm
 170 NS: ha (.) ehh mm I think in homeopathy you need a sound firm base (.)
 171 and from that you can go off and do things that you might not have
 172 learned but seem right to you I think
 173 CC: so what you're saying
 174 NS: I don't think it's good to start that way
 175 CC: fine (.) I think
 176 NS: y' know in the first year say (.) uhm (.) it feels like this person needs
 177 this remedy or I think this is (.) ehm (.) tch (.) a problem in their
 178 childhood and give a remedy for that I think you need ((inaudible))
 178 before you can go off in that stuff (.) not everybody would agree
 179 CC: (.) so (.) what is homeopathy
 180 NS: tch (.) phew (.) it's some kinda way of (.) helping people get healed
 181 that uses natural laws (.) and to me it's in different parts which joined
 182 together the medicine the remedy is important but it might not be vital
 183 (.) I think about that sometimes ehh (.) umm the main thing I think is
 184 keeping the law of similars that like cures like understanding a person
 185 in the best way that you can as a homeopath (.) tch (.) and then
 186 applying that to (.) the remedies that we have finding one that fits (.)
 187 that person to me that's a least half of it and maybe the other half is
 188 giving the medicine some people have experimented in not giving the
 189 medicine and things have happened (.) so who knows (.) its definitely
 190 energetic stuff it's not =

191 CC: = yeah =
 192 NS: = chemical (.) there's no drug reaction of any kind (.) so that's (.) the
 193 kind of ways I look at homeopathy
 194 CC: yes (.) you are almost saying that you can sort of be with the person
 195 and you don't have to give a remedy and there can be changes
 196 NS: that's for sure yeah because people very often it's it's talked about a lot
 197 in colleges in groups of homeopaths people very often notice a change
 198 some point between tch (.) them coming to see you before they're even
 199 got the remedy cos y'know generally we wouldn't kinda just give a
 200 remedy =
 201 CC: = yeah =
 202 NS: = as they came went out the door (.) most of us ((inaudible)) the first
 203 time and it very often happens that when they come back to report at
 204 the next consultation they say eh mm y' know I enjoyed the
 205 consultation but two days later I felt really well maybe that's the day
 206 you chose the remedy or posted it or something then I don't know but
 207 yeah (.) something happens
 208 CC: so (.) how does homeopathy work
 209 NS: phew I don't know (.) eh
 210 CC: if you can tell me you get the Nobel Prize (.) ha
 211 NS: ha (.) (.) yeah well y' know eh on a practical physical level nobody
 212 knows yet there's lots of work been done in it personally I don't really
 213 worry to much that (.) how does it work it works because the person
 214 comes to see you (.) tch (.) with a problem which usually turns out to
 215 be a linked set of problems and you as a homeopath listen to them in a
 216 particular way eh (.) understand them in a particular way tch (.) and
 217 kinda use that linked information to (.) choose a medicine the first year
 218 my son was ((inaudible)) (.) so I think it works by you understanding
 219 the person
 220 CC: is there any proof that homeopathy works
 221 NS: yes there's lots eh mm of pretty good studies apparently not good
 222 enough to convince the medical profession but eh (.) yeah me it
 223 works (.) there's proof every time somebody gets well after they've
 224 come to see you the proof is in the consulting room and in the person's
 225 life afterwards doesn't matter if the medicine did it
 226 CC: you mentioned the medical profession do you feel it's quite important
 227 that you have to prove it to them
 228 NS: no I don't some people do =
 229 CC: = hmm =
 230 NS: = eh (.) I think that's the wrong way to go about things (.) and there is
 231 eh (.) mm there's obviously a move on the part of some of the
 232 medical profession to look at homeopathy and even to practice it (.) so
 233 let them come to homeopathy rather than prove it works the the scien
 234 scientific stuff that's going on in physics and one or two places is
 235 interesting eh (.) and they might be on to something about the
 236 mechanism eh (.) um and that's fine that's good y' know but I
 237 wouldn't sink money into it myself ha ha
 238 CC: ha right eh um (.) um er is there a homeopathic diagnosis or do you
 239 call it something else
 240 NS: it's not a diagnosis in the the medical way eh we would certainly take

241 note of peoples medical conditions (.) but they might not be the key
 242 thing in choosing the medicine ehh um it's more like an analysis of tch
 243 (.) all of their stuff their medical condition mental condition emotional
 244 condition (.) and ehh (.) there kind of (.) ehh problems along the way in
 245 life it's a kinda analysis I suppose in how those things connect rather
 246 than a diagnosis
 247 CC: so you sort of look at the whole picture would that be correct to say
 248 that
 249 NS: yeah the whole picture being as big as possible =
 250 CC: = right =
 251 NS: including family life experience (.) y' know as big as possible rather
 252 than just a condition
 253 CC: hmm (.) so what aspect of the person draw you to this
 254 NS: ehh (.) phew It's really the way the way that they relate to the world (.)
 255 on all levels so ehh umm (.) tch if they (.) I'll try and conjure up a
 256 crude example if they feel ehh um the cold a lot and if they (.) ehh mm
 257 (.) were brought up in a boarding school a cold environment in
 258 ((name)) then you start to see a couple of things linking together
 259 perhaps ehh um (.)so you are looking for a kinda picture that links the
 260 different levels (.) ideally
 261 CC: yes
 262 NS: that kinda thing
 263 CC: is there always one correct remedy you mentioned earlier this ehh (.)
 264 constitution approach
 265 NS: yeah (.) I think so ehh umm (.) it's hard to say I think there are
 266 differing opinions ehh (.) the way I go about it is to assume that there
 267 is only one remedy for this person a at this point anyway chi (.) and
 268 maybe it's the same one they needed when they were young as well so
 269 I would take into account there younger life as well (.) ehum (.) if that
 270 doesn't all fit together it's what's happening now that's most important
 271 but I I think there is one (.) remedy for a person in that period at least
 272 CC: do you treat people according to Hahnemanian principles and methods
 273 NS: basically yeah but I tend ehh (.) mm not to be to strict about it as time
 273 goes on again that's the base I was talking about
 273 CC: yeah
 274 NS: that's the strength (.) ehh mm we do have to acknowledge he's been
 275 dead for a long time things have changed (.) ehh um but basically I
 276 think you could take his organon work on that and you'd do very well
 277 ehh um it it maybe that ehh um that we need all the new remedies
 278 were developing now because people have change the world has
 279 changed (.) I think I don't think remedies hold as long with people
 280 these days I think things have changed in terms of speed and (.) in the
 281 world and in peoples lives y' know I think maybe people burn up the
 282 remedies quicker so that might be different from his experience (.) ehh
 283 it's hard to say
 284 CC: could you explain some of the reasons how homeopathic treatment can
 284 (.) benefit the patient
 285 NS: tch (.) yeah the treatment right from the beginning people often say to
 286 me ehh umm (.) at the end of the first consultation (.) I never said all
 287 that to one person before and a (.) somebody said to me very recently

288 that ehh um if you hadn't put two and two together about certain things
 289 cos she hadn't never said then to same person before (.) one might be a
 290 physical thing one might be an emotional thing or one might be just the
 291 way her life has gone (.) but people often say ehh um I realise things
 292 about myself I didn't half an hour ago so that's one benefit tch (.) ehh
 293 um (.) the other benefit is strengthening that persons constitution rather
 294 than focusing on the (.) particular problem so the benefit generally
 295 CC: ((cough))
 296 NS: and generally their problem goes away if the deeper (.) ehh um aspects
 297 are addressed in the consultation and with the remedy (.) there's
 298 endless benefits ha people get (.) people get really excited about the
 299 whole idea and it benefits them in that they look into it and perhaps
 300 use it with themselves there family on a simple level so (.) that's the
 301 kinda ehh tch (.) front line then if they have an illness they can help
 302 themselves and if they have a: deeper problem they know that they can
 303 avoid drugs by going to see a homeopath and using homeopathy kinda
 304 ((door bell ringing in the background)) thing
 305 CC: ehh (.) ((inaudible)) what is a symptom
 306 NS: a symptom well ehh um (.) I was taught and do believe that it's a
 307 symptoms like a (.) cry for help or a sigh of: how things are wrong so
 308 rather than a symptom being a problem it's an indicator on how to get
 309 to the solution so symptoms are good things as long as you use them (.)
 310 to to get some medicine or some help that takes away the reason for
 311 them does that make sense
 312 CC: mm (.) what would you treat with homeopathy
 313 NS: ehh always the person ehh um tch (.) the condition is only part of it and
 314 if you mean what conditions would you treat
 315 CC: yeah
 316 NS: I don't really put a limit on it although you know if somebody has
 317 cancer or a severe mental condition like schizophrenia then you might
 318 weigh up whether you take on the case =
 319 CC: = hmm =
 320 NS: and you might ehh um (.) y' know you might not be vastly optimistic
 321 about their outcome about it if I take the case on then I'm open to
 322 whatever might happen (.) so tch (.) I personally I don't think I would
 323 treat somebody with schizophrenia unless I was part of a team (.) ehh
 324 (.) most other thing I don't think that would stop me I would want to
 325 find out about the person =
 326 CC: = umm =
 327 NS: because I think if you get that remedy for that person tch (.) then
 328 almost anything can be helped or cured
 329 CC: how do you go about getting this remedy the correct remedy for the
 330 person .are there tools
 331 NS: yeah there are tools there are there are intermediary tools between (.)
 332 you listening and then giving the remedy so the repertories that we use
 333 and the materia medica (.) all the information that's been collected tch
 334 (.) from homeopaths by homoeopaths has been put into a form that you
 335 can access and use (.) because you can't memorise details of all the
 336 remedies there's (.) there's to many ehh um in Hanheman's time I think

337 he got up to one hundred and fifty something like that and he knew 338
 them all but once you get passed that you just (.) I doubt whether
 339 anybody could remember much about three hundred five hundred
 340 there's supposed to be three thousand now (.) so there are these tools
 341 yeah ehh (.) the first tools is the pen and paper cos you'll write down a
 342 lot of what people say at least I do ehh mm (.) because later on in
 343 reflection something that you didn't think was important at the time
 344 that you didn't write down might turn out to be the key or link up with
 345 other things (.) tch (.) ehh um (.) tch (.) a good set of ears and eyes as
 346 well cos quite (.) quite a bit of it can be observation ehh not just what
 347 they say how they move and how they act and how they express thing
 348 through their body tch (.) ehh and then after the consultation when
 349 you're looking at the case you can take the information that you pull
 350 out sort of characteristics of that person and the problems and you can
 351 put it through a process with the the books the repertoires and either in
 352 book form or computer programme tch (.) and then you can check it on
 353 all the literature we have got for the past two hundred years (.) but
 354 that's the kinda tools we can use
 355 CC: (.) so how would ehh homeopathy view the illness (.) in the person
 356 NS: that's ehh (.) a set of clues as to what needs to be addressed (.) ehh
 357 umm it doesn't matter what the illness ehh it will have character (.)
 358 characteristics and that person will experience it differently from
 359 another person with the same named illness but eh yeah a unique set of
 360 symptoms .that give you the clues you need to find the remedy for
 361 CC: what is the homeopathic consultation
 362 NS: tch it's a meeting (.) of minds and (.) maybe more than that a meeting
 363 of spirit a meeting of energy a meeting anyway that is the beginning of
 364 change for that person if all goes well ha
 365 CC: quite good
 366 NS: high faluting
 367 CC: no that sounds =
 368 NS: = that's what I really believe
 369 CC: hmm (.) could you describe some of the different ways that you would
 370 approach a consultation
 371 NS: yeah I always come in ehh as openly as possible ehh umm and very
 372 often you don't know what the person's condition or problems are
 373 before
 374 CC: yeah
 375 NS: and generally they just book in (.) so really open and accepting and ehh
 376 (.) just kinda excited about (.) what what's going to come out of this
 377 because peoples stories are amazing (.) ehh tch (.) so (.) you can learn
 378 stuff in the consultation about human nature ha often you do that you
 379 didn't (.) that add to your knowledge or you haven't experienced
 380 before (.) so (.) what was the question what were you wanting there (.)
 381 my =
 382 CC: = ehh =
 383 NS: = oh my approach to the consultation
 383 CC: yeah
 384 NS: ehh yeah just be open and accepting and ready for anything ehh umm
 385 as I say I'm hoping not to have to say too much in the first part of it tch

386 (.) but sometimes it has to be like ehh mm an exchange me asking
 387 questions all the time and prompting them you have to be ready for
 388 that and (.) you know by now I don't really need a check list of things
 389 that I want but you've got to be you've got to keep yourself slightly
 390 alert cos you can get so lulled into peoples stories that you forget to
 391 ask them important questions (.) like what do you like for breakfast
 392 and stuff like that ha
 393 CC: ha he
 394 NS: but yeah open
 395 CC: umm (.) you said you learned things about human nature (.) during the
 396 consultation
 397 NS: tch (.) quite often it's ehh umm just how courageous people are (.) to to
 398 be still going after the things that happened ehh um tch (.) you also y'
 399 know you also hear things that make you think (.) well this person
 400 thinks they have a terrible flaw in their character (.) ehh um but I do
 401 that hee y' know it makes you think about yourself in relation to the (.)
 402 human race and ehh (.) yeah (.) you'd you learn all kinds of things it's
 403 about the ways people have of coping about amazing stuff (.) that
 404 kinda thing
 405 CC: mm (.) is there such a thing as a therapeutic relationship
 406 NS: yeah I think so (.) so that's why I say do we always need the remedies
 407 always tch (.) ehh um and I think in a (.) case of the homeopathic
 408 consultation it comes about through the person being allowed to tell
 409 you all their stuff cause were not a specialist in psychological
 410 complaints or physical complaints we just take it all ehh um tch (.) so
 411 because of the way your listening and asking questions and the way
 412 that they are able to talk ((phone rings)) I think that's the beginning of
 413 the change ((phone rings)) to health hopefully =
 414 CC: = ((phone rings)) umm =
 415 NS: = so it can be it can be therapeutic that way
 416 CC: okay (.) how much time would you spend with a patient
 417 NS: tch generally it seems to be an hour and a half first time it can be two
 418 hours and in can be over in (.) forty minutes ha =
 419 CC: = ha =
 420 NS: = but generally an hour and a half
 421 CC: It's quite a long time or is it ehh (.) is that sort of
 422 NS: yeah well I usually I never book in anybody right away after a new
 423 patient cos it might be one that stretches out and then y' know people
 424 might get quite upset sometimes and if they get upset after an hour and
 425 a half you can't chuck them out =
 426 CC: = hmm =
 427 NS: = I've got someone else now hears the ((inaudible)) but also tch (.)
 428 some people kind of take an hour or more to kinda get into stuff they
 429 hadn't thought about or realised and then they come out with lots of
 430 stuff so (.) an hour and a half is not necessarily very long
 431 CC: do you give ((inaudible))
 432 NS: sometimes you know in the first five minutes =
 433 CC: = mm =
 434 NS: = sometimes they tell you (.) the first thing they say and then two or
 435 three other things you could get the case from that but you need to

436 kinda add to the information
 437 CC: so there is potential for it (.) it can be an hour and a half or two and a
 438 half minutes ha
 439 NS: yeah
 440 CC: ehh what training or life experiences have you personally contributed
 441 to the consultation process
 442 NS: well the training's going to college going to a homeopath yourself ehh
 443 tch (.) studying constantly in a way (.) homeopathy I mean the other
 444 things that I was interested in before I discovered homeopathy like
 445 Chinese philosophy tch (.) Zen and beatnik poetry and all sorts of stuff
 446 it's the kinda brings you to a point where you are ready to study
 447 homeopathy it can still be used ehh um tch (.) interest is in my interest
 448 is in (.) Daoism for instance Chinese philosophy it comes in very
 449 useful I think ehh and I was lucky enough to go to a college that
 450 encouraged that chi (.) ehh um I've travelled a lot cos when I was
 451 young we moved to different countries so I don't have like a fixed
 452 Scottish idea of how how people tick
 453 CC: that's good ((inaudible)) interesting
 454 NS: yeah it helps it helps ehh um I've never lived in England but a lot of
 455 my patients are English and I've come across people from all different
 456 countries including England when I've been (.) abroad so if you've got
 457 a wider view it helps
 458 CC: yeah that's interesting beatnik poetry
 459 NS: ha ha
 460 CC: who would that be
 461 NS: Ginsberg and people like that but actually probably Kerouac
 462 CC: yeah On the Road isn't it
 463 NS: yeah On the Road I discovered very young (.) and it put me on to
 464 Buddhism these kinda things jazz (.) poetry ehh um so so (.) yeah you
 465 have these things in your life that you are interested in for no apparent
 466 reason cos (.) nobody has ever told you about them you hear
 467 something or pick it up in a book (.) and it's for you and tch (.) so then
 468 you develop that and you go along these lines and find out what you
 469 can about this this thing if it's (.) ehh umm a beatnik way of life or
 470 Buddhism or whatever ehh umm music and songs I find a great help in
 471 ehh umm understanding people eh (.) the song is like a little
 472 psychological poetry often of somebody I've actually used songs in
 473 teaching because ehh um if you've got a really good songwriter
 474 who's writing possibly from his own life or her own life in three
 475 minutes they've crystallised something you can treat that as a case =
 476 CC: = yes =
 477 NS: = you can say you said this here and you said this here and ehh (.) has
 478 mentioned that if you put these things together you have a case that
 479 could lead to a remedy
 480 CC: yeah
 481 NS: so just for a way in fun sometimes I do that
 482 CC: It's almost (.) a sort of different medium but ehh methods being
 483 adopted from the homeopathic approach
 484 NS: you can adapt ehh um (.) existing things like songs
 485 CC: ehh

486 NS: to help your (.) practice or teaching or
 487 CC: you said something about music if somebody was to play a violin or a
 488 saxophone or something (.) do you see that kind of can you understand
 489 that in a sense is there a story there from the notes or if somebody was
 490 improvising for example
 491 NS: yeah could be could be but is much more difficult to treat ha ha but ehh
 492 CC: what remedy could that be
 493 NS: yeah but yes yeah people play the saxophone all different ways
 494 CC: hmm
 495 NS: ehh umm I've seen Tommy Smith play saxophone and I don't think he
 496 has got a heart
 497 CC: It's funny you should say that a lot of people have said that
 498 NS: oh well
 499 CC: he is technically sort of (.)
 500 NS: yeah
 501 CC: his wife Laura ehh (.) ((inaudible)) alto she's pretty interesting
 502 NS: I've hear about her but I've not seen her yeah is she American
 503 CC: no she's Scottish ehh umm she's getting quite interesting sounds from
 504 that alto
 505 NS: that's interesting
 506 CC: I mean one thing I'm not sure about her approach is just ehh umm (.)
 507 it's sort of too fast all the time y' know it's sort of three hundred mile
 508 an hour which is fascinating y' know but sometimes its quite nice to
 509 have a slower sort of moody blues type (.) yes she's really an amazing
 510 player
 511 NS: maybe she's just reflecting the speed of the world because =
 512 CC: = mhm-mm =
 513 NS: = cos if you look at ehh umm folk music American bluegrass or
 514 something they all play at one hundred miles an hour I don't see the
 515 point to it it just shows your technique skill I would rather ehh umm
 516 hear John Coltrane play a few notes over a minute
 517 CC: yeah I know two notes sometimes can just he ha if you get it =
 517 NS: = yeah =
 518 CC: = can be quite interesting one note see (.) ehh I'm an alto player
 519 myself
 520 NS: oh really
 521 CC: oh ((inaudible)) I'll get back into it (.) I shouldn't really deviate from
 522 the interview (.) but yeah =
 523 NS: = It's okay you can edit the tape ehh ha
 524 CC: mhm-mm ehh (.) what expectations do you have of patients
 525 NS: well I need to hear what the problems are he ha but ehh (.) just that
 526 they come and tell me their stuff but I don't demand all their deepest
 527 stuff I mean I if someone doesn't want to talk about something that's
 528 fine (.) really you can work round that I think I don't think it's fair to
 529 keep probing at people's wounds or anything chi ehh maybe that's
 530 different from ehh umm (.) psychotherapy I'm not sure but I just
 531 accept what they say ehh and if later on in the consultation I'm asking
 532 questions and I get the idea that their not wanting to ta touch on
 533 something then I'm not going to push (.) and if they do say something
 534 and I say could you tell me more about that kinda probe in that way

535 and they cut it short then I'll accept that and (.) but just to be as honest
 536 as they want to be
 537 CC: okay so what expectations do patients have of homeopathy
 538 NS: that varies a lot
 539 CC: yes
 540 NS: varies a lot yeah most people come to have their symptom go away ehh
 541 um some people come to be cured whatever that is ehh umm (.) some
 542 people have no idea why they came
 543 CC: really
 544 NS: well I'll give you an example (.) ehh mm at my practice in ((name of
 545 establishment)) chi (.) about six to eight weeks ago this woman can in
 546 she had walked in off the street and booked in that day I was in in the
 547 afternoon and ehh umm she was from a nearby town but she lived in
 548 America most of her life she was I think seventy or seventy two and
 549 ehh (.) she had she complained of bronchitis (.) and ehh told me all
 550 kinds of things about herself and ehh (.) I explained that what I needed
 551 to do was to choose a medicine she was going (.) to be going to
 552 London and then back to the states so I said okay I'll choose a
 553 medicine and send it to London so that you can get it before you go
 554 and then perhaps you can contact me and let it me know how it went
 555 CC: right and
 556 NS: and we could further the (.) treatment y' know by email or whatever so
 557 about ha she seemed to enjoy the whole thing
 558 CC: okay
 559 NS: and ehh she was quite a performer anyway the receptionist kinda
 560 observed that as well I got a letter a week or two ago ago saying I
 561 never did take your three little pink pills there white (.) by the way (.)
 562 ehh and ehh (.) I expected you to give me all sorts of advice about diet
 563 and what to do to help my bronchitis I don't see how three little pills
 564 are going to help but I've kept them anyway as a souvenir of how I
 565 was scammed in Scotland he ha so so I thought about it about and I
 566 personally thought she had come to tell me her story
 567 CC: hmm mm
 568 NS: she had a very tragic story
 569 CC: mm
 570 NS: ehh but she seemed to come for her own reasons ehh umm I don't
 571 think either of us was satisfied he ha but ehh (.) so that's an example of
 572 of people coming for different reasons sometimes your not sure of the
 573 reasons (.) quite often people come come to tell you their story and the
 574 stuff they've never told anybody ehh (.) (.) and that it might be to them
 575 (.) the background reason or a slightly separate reason they might say
 576 at the beginning (.) so they come for lots of reasons (.) I just to hope to
 577 listen to them very well and to help them in some way (.) I've been a
 578 bit frustrated a couple of times when tch (.) people have have brought
 579 children young children a couple of times with hmm well one one child
 580 was autistic and the other one had a similar chi condition an extreme
 581 condition as well and mm both cases they didn't give the remedy
 582 y'know the whole family came and they talked about the child and I
 583 said well I'm not sure what will happen but let's (.) I'll choose a
 584 medicine let's try it never came back for the second consultation

585 or cancelled it tch (.) that's been a bit disappointing but (.) that's their
586 choice (.) you wonder why they did come in the first place tch
587 CC: yes
588 NS: well I always think it's worth doing worth seeing people whatever and
589 ehh umm (.) y'know and it's interesting remedies can be very long
590 term so someone might come cancel the next appointment cause
591 nothing happened but once or twice I've found out that people have
592 done well (.) not realised it or not acknowledged it ehh and quite often
593 I think I'm sure that remedy will do something for that person
594 eventually it won't necessary work in the month between you seeing
595 the person and them coming back (.) very often do work in seconds or
596 min minutes after simply happens but sometimes quite often I've had
597 ehh people chi come and say I didn't notice anything at all until just
598 the other day (.) and this is a month later three or four weeks it's
599 something that has changed so much for them to notice (.) it's different
600 for everybody
601 CC: what are the reasons for that do you think
602 NS: sure are but I don't think there you could put them on a table
603 CC: ehh okay
604 NS: because it's such an individual thing (.) tch I mean you get ehh (.) ehh
605 you get huge strong guys who do physical work and you give them a
606 two-hundredth potency and it knocks them out (.) it's seems like it's
607 the wrong energy for them and maybe they'd done better on lower
608 potencies gently and then you get babies who need a 1 M they take it
609 and use it and are better quickly without any aggravation or anything
610 like that
611 CC: is it some thing to do with you mentioned mentioned earlier the vital
612 force
613 NS: yeah
614 CC: for some reason it's different between people
615 NS: I think so that's the thing where you can see some kind of pattern yeah
616 ehh (.) it seems like babies and young children have got a high vital
617 force perhaps unspoiled sometimes (.) they can use the higher
618 potencies perhaps it's not that your going with a ((inaudible)) babies
619 but but ehh umm perhaps an older person even though they seem
620 stronger and healthy ehh had lots of things happen to them perhaps lots
621 of ehh orthodox medication suppressing stuff (.) for whatever reason
622 their vital force might not be as strong as it looks (.) sometimes it
623 obvious people with ME and things it's it's very weak and you need to
624 be quite careful with them sometimes
625 CC: okay (.) so you mentioned potency (.) how would you get to the
626 potency?
627 NS: you try and match the potency the numbered potency to your
628 estimation of the vital force of the person ehh umm tch if it's an acute
629 situation then you might be more energy around you might give a
630 higher potency tch but looking at the chronic picture you might decide
631 to keep low potency because the person doesn't have much vital force
632 it seems so you try and match it (.)
633 CC: so what are your feelings about being interviewed today
634 NS: ehh well I'm enjoying it ha ha I ehh just came to see what would

635 happen to see if I could help
 636 CC: is there anything else you would like to tell me about homeopathy or
 637 ask me anything
 639 NS: ehh I think it has huge (.) potential (.) and it would be nice if it was
 640 much more widely known but some of the best things are not
 641 necessarily available to everybody which is true of music as well if
 642 John Coltrane was in the charts every week I'd might get a little tired
 643 of him
 644 CC: yeah
 645 NS: ha ehh mm (.) but it's incredible what it can do (.) and (.) so you really
 646 can't don't want to put a limit on the possibilities with the person (.)
 647 and of course not everybody realises that and it doesn't work every
 648 time either for whatever reason ehmm (.) but it is incredible what it can
 649 do and I don't necessary mean the remedy I mean the whole thing of
 650 the consultation homeopathy (.) it does change people's lives (.) I had
 651 ehh umm a patient I was thinking about recently (.) who came a while
 652 ago three or four years ago and she had had a baby had suffered from
 653 post natal (.) depression and it went on for a year she got no help from
 654 anything that she tried (.) and ehmm (.) one dose of one tablet and she
 655 just felt a new person again ehh (.) changed her life and I know that a
 656 little while later when I heard from her she was still good so (.) that
 657 kinda thing makes it worthwhile because you could spend a lot of time
 658 doing counselling or psychotherapy or using medication (.) but the
 659 right remedy for that person ehh umm and again in that case it was
 660 linked back to her life before having her baby and everything it was all
 661 rounded the whole picture but just a simple thing it seemed to
 662 understand what she was portraying and gave the remedy I thought
 663 was appropriate and everything just went well to me that's very
 664 economical if you like =
 665 CC: = certainly =
 666 NS: =and that doesn't happen every time
 667 CC: no
 668 NS: people are very complicated sometimes and take a lot of unravelling
 669 but sometimes but that's a process and ehh they can benefit along the
 670 way and so can you (.) because every person's unravelling is different
 671 (.) so homeopathy is good stuff ha
 672 CC: thank you nice to meet you very interesting
 673 NS: your welcome and good luck with the study (.) bye =
 574 CC: = thank you again

Recording equipment switched off.

ORIGINAL PAPER

Medicine, rhetoric and undermining: managing credibility in homeopathic practice

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This article examines homeopathic practitioners 'real life' accounts, and illustrates the ways in which they negotiate their homeopathic practices as contingently formulated ongoing social events in research interview settings. Interview transcripts were analysed in a qualitative framework using discourse analysis. The findings show that practitioners construct homeopathy and defend their own individual practices either by 'alignment-with-medicine' or by 'boosting-the-credibility-of-homeopathy'. Homeopathy is also negotiated and sustained as an 'alternative' to notions of conventional medicine, which is the accepted yardstick for practice or as a practice that is portrayed as problematic. Overall, managing personal credibility is accomplished through specific ways of accounting that tend to marginalise homeopathy. Developing and establishing homeopathic practice further as a discipline in its own right is offered as a 'nucleus' to reduce continuing marginalisation.

Homeopathy (2008) 97, 76–82.

Keywords: Homeopathy; Homeopathic discourse; Discourse analysis; Credibility; Marginalisation; Progress

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Received 11 December 2006; revised 14 February 2008; accepted
14 February 2008

Introduction

In terms of society the discourse of medicine is long established and powerful, suggesting that language used to describe and give meaning to health related ideas and practices reflects the dominant medical discourse.^{1,2} Homeopathy is a form of medicine founded by Hahnemann (1755–1843), it appears to have made little impact on current medical thinking. Homeopathy has neither the institutional backing, nor the theoretical persuasiveness to challenge scientific standards which would lead from marginalisation to wider acceptance.^{3,4} The status of conventional medicine has consequences for all sorts of social actions that legitimise the acceptance of particular ways of constituting social reality about medical, health practices and illness.^{2,5–8} In comparison to conventional medicine, homeopathy also contributes to a long therapeutic history; in contrast, its aims and beliefs are somewhat opposed to those of the medical mainstream.⁹

Traditionally, homeopathic studies attempt to prove aspects of clinical efficacy in an effort to make an impact in the wider medical environment.^{10,11} Moreover, accepted

scientific research methodology becomes the standard against which other forms of medical research are measured. The authority of conventional medical practice as a recognised, scientifically researched, discipline leads to attempts to evaluate the efficacy of other non-traditional therapeutic interventions in terms of conventional medicine. Evaluated in this way, homeopathy is found not to quite fit the accepted medical criteria. As homeopathy is not evaluated on its own terms, but it is judged on conventional medical territory, it is predictable that it will lose credibility and status as a result of the power of conventional medicine and medical discourse.

In the context of biomedical research, evidence is viewed from an overtly rational perspective as an accurate factual representation of events.^{5,6} Its findings are not usually considered as social actions constructed in interaction.

One way of approaching participants' practices is by paying attention to the meanings of actions in interactional settings, examining in particular how participants themselves make sense of their practice.¹² In this context, discursive studies have shown that attributes are not stable expressions of causal thinking but are worked-up to manage attributions of responsibility, namely, blame, mitigation, accountability^{12,13} or show how people are portrayed as a 'normal person doing normal things'.^{14–16} Medical studies in analogous contexts using applied discourse analysis (DA) have shown that such outcomes can be viewed as a negotiated achievement.^{7,8,13} Moreover, by drawing on a body of work representative of everyday social life, medical work and in scientific contexts, medical rationale is viewed as discursively constructed.^{1,6–8}

DA is an appropriate analytical frame for approaching aspects of homeopathic practice; by applying a discursive perspective, common assumptions and strategies taking place in social interaction are re-read. DA reveals multiple interpretations of the phenomenon by the very people who practice, advocate and use such a contested treatment. DA seeks an in-depth focus on the participants' accounting activities. In contrast to traditional approaches, participants' views provided in interviews are treated as a neutral, representative pathway to an underlying reality. In other words 'constructing a description as independent of the agent doing the production', is defined as 'out-there-ness'.¹⁷ DA can explain how participants' descriptions function within the particular contexts in which they are provided and with specific effects.^{12–14,18–20} I examine the key area of the interview, a social interaction where homeopathic practice is not received passively, but negotiated, resisted, rendered meaningful, and is interpreted into the participants' practices. The focus of this study is with the ways in which homeopathy is talked about in the interview setting.²¹ The aim of this paper is to examine the actions accomplished and explain how homeopathic practice comes to be marginalised from mainstream acceptance by detailed analysis of practitioner's account of their practice.

Materials and methods

The study was conducted in the UK. Ethical approval was granted by a Multi Centre Research Ethics Committee prior to commencement of data collection. Practitioners were selected on the basis that they practice homeopathy and were affiliated with a recognised professional organisation. Ten medically trained and 10 non-medically trained practitioners participated. The data presented here are selected from tape recorded semi-structured interviews varying from 60–90 min with male (7) and female (13) practitioners. The extracts presented below pertain to the broader patterns, strategies from the main body of data, offering an insight into the variety of discursive features and resources available to the participants.

All interviews were transcribed verbatim using an abbreviated version of the Gail Jeffersonian style.²² Pseudonyms are used for all participants in an abbreviated format and CC as the researcher. Of the four interviewees, only NS is a non-medically trained practitioner.

Analytical procedure

In this study a discursive social constructionist perspective is deployed by applying DA.^{23–25} Social construction is a term used to view the self, objects and experiences as being accomplished in interaction, through participants' orientations in talk and over discourses rather than clearly defined pre-existing factual frames of reference.^{17,23,24} Here, the style of DA is informed by an ethnomethodology/conversation analysis framework^{26–29} with a critical discourse analytical perspective.^{19,30,31} This form of DA merges a range of influences drawing from the 'bottom up' approach where attention focuses on the features of sequential action orientation of talk in situ and the performative qualities of situated social practice sometimes referred to as talk-in-interaction²⁹ synthesised with a 'top down' perspective which focuses on power and wider ideological practices.^{30–32} This analytical framework is generally referred to as perspectives in discursive psychology.^{12,19,30,31,33} Hence, I focus on practitioners' talk and the wider cultural, socio-political and historical influences of discourses per se.^{19,34}

As a method of analysis I incorporate a critical stance.^{19,30,31} and draw upon the Discursive Action Model (DAM)^{12,33} One of the central characteristics of this method is its focus on action, rather than cognition examining formulations and the inferences people make available in talk. I examined specific features of the data asking: 'why this utterance here?', 'what is this participant doing?' and 'with what effects?'. A second feature of the DAM is 'fact and interest': how people manage the dilemma of stake and interest in their own accounts and talk up their experiences as factual by deploying rhetorical devices, such as lists,³⁵ extreme-case formulations,³⁶ 'at first I thought . (mundane X), but then I realised.' (extraordinary Y).^{16,37} The final feature in the DAM is how people attend to the notion of personal accountability as a discursive

practice. People attend to personal accountability within the reported event. That is, whether the report of the event was based on a testimony of a reliable witness, or presented as a mundane discussion of some potentially controversial matter. Therefore, accounts can be examined to see how people accomplish the action of defence of their practice. If the account is motivated by self-interest then the veracity of the account will be undermined.

Findings

Practitioners, in interaction with the researcher, offer two rather different broad strategies as: alignment-with-medicine and boosting-the-credibility-of-homeopathy, both of which tend to marginalise homeopathy from mainstream acceptance.

‘Alignment-with-medicine’

In the first two extracts the practitioners account for and defend their practices by aligning with medicine, seen in the following extracts:

Extract 1

- CC: so what is a homeopath?
D: what is a homeopath (.) well I’m not a homeopath
CC: no
D: I’m a homeopathic doctor
CC: yes (.) okay
D: and a complementary medicine therapist practitioner
(.) a homeopath in the usual accepted (.) term is layperson
who’s using homeopathy not a medically qualified

Extract 2

- CC: so (.) what qualities are needed to become a homeopath?
HP: I would make a distinction between homeopathic
doctor and a
CC: okay
HP: homeopathic practitioner because anybody can
study homeopathy and prescribe it and therefore be
named a homeopath it is not a restrictive
CC: yes
HP: label but if you mean (.) the qualities to become
a good one then (laugh)
CC: (laugh)
HP: (laugh) I think you require considerable professional
knowledge of medicine psychology psychiatry

Practitioners D & HP accomplish similar, contingently formulated interactional business, illustrated through a contrast (medicine/homeopathy) formulation. This strategy portrays a fragmentation of practice, identifying a demarcation between the medically oriented practitioner and the

homeopath, whom are positioned very differently in this interaction. The implication is to facilitate the impression that the information provided is an accurate and factual portrayal of the 'alternative' counter practitioner. In so doing the practitioners D & HP align with notions of medicine as the taken-for-granted position against which to measure everyday practice.

Second, in Extract 1 D's account is a negotiated achievement with the researcher; it constitutes the 'homeopath' in an alternative frame when contrasted to the 'homeopathic doctor', D spontaneously highlights the significant features attributed to both a 'homeopath' and 'homeopathic doctor'. The features that D makes available could be heard as an accurate portrayal that a 'homeopath' is a 'layperson who's using homeopathy' in a contrast to a 'medically qualified' homeopathic doctor. This discursive formulation is designed to rhetorically manage specific sensitive issues. D goes on to reinforce this inference by spontaneously invoking the 'layperson' which on this occasion is constituted as a potentially negative attribute. By contrasting a 'homeopath' with a 'homeopathic doctor' D implicitly infers that the 'homeopath' is on the fringes of conventional medicine and medical practices. This implies a potentially un-equal status characterised in relational terms by the way that D aligns favourably with the category of 'homeopathic doctor'.³⁷

Third, a further example presented in a similar fashion to D's strategy, is observed throughout HP's account which spontaneously and immediately invokes a distinction between a 'homeopathic doctor' and a 'homeopathic practitioner'. In so doing HP talks up the qualities of a good practitioner in relation to acquiring adequate professional knowledge of medicine, psychology and psychiatry. To substantiate and portray her claims as significant to the interaction she contrasts the 'homeopathic doctor' and 'homeopathic practitioner'. In this instance 'anybody' can be heard as an extreme-case formulation suggesting that the study of homeopathy is widely available. 'Anybody' is proposed as evidence of the excessiveness of unspecified others who can study and prescribe homeopathy and thus be known as a 'homeopath'. HP follows this by qualifying her claim, 'it's not a restrictive label'. On this basis 'anybody' is an extreme-case formulation.³⁶

By contrasting a homeopathic doctor and homeopathic practitioner in a medical/non-medical evaluative frame HP is establishing and legitimising the homeopathic doctor as the 'hegemonic principal', the taken-for-granted yardstick. In making this differentiation HP implicitly aligns her practice with conventional medicine. By invoking 'medicine, psychology, and psychiatry' HP constructs a three-part list rhetorical device. Three-partedness is a normative principle underlying people's actions and a generic organisational feature of talk. Generally, lists have three parts and are completed by the provision of the third item which maybe 'etcetera' or a suitable third element.^{17,35} On this occasion HP's three-part list adds rhetorical strength to her claims and at the same time emphasises the diversity of the knowledge base to emphasise the broad range of mundanely accepted professional knowledge considered

representative of a 'homeopathic doctor'.
As a consequence in both extracts interview talk
observed through question/response interactive sequences
homeopathic practice is demarcated and marginalised
from mainstream acceptance if the claims are considered
a broader social perspective.19,30,31,41

'Boosting-the-credibility-of-homeopathy'

'Practitioners' accounts worked in a somewhat different
way to marginalise homeopathic practice. This is observed
by boosting-the-credibility-of-homeopathy by undermining
potential criticisms and describing homeopathy as problematic,
as is apparent in the following extracts38,39,40:

Extract 3

- CC: could you tell me some thing about yourself?
NS: ...I'll tell you how I came to homeopathy (.) I've always
been interested in alternative things ways of living
(.) but not really looked into (.) alternative medicine very
much but when my son was (.) one year old which is 20
years ago now (.) he had constant ear infections one winter
and after getting normal treatment antibiotics about
three (.) we just thought it's not good enough I went to
some classes in homeopathy found (.) with some help
from the person who was giving the classes (.) the
homeopath I found a remedy that would stop ear
infections instantly

Extract 4

- CC: could you describe some of your reasons for getting
interested in homeopathy?
DH: (.) well I wasn't interested in homeopathy when I
started in the ((name of establishment))
CC: so why
DH: I was interested in a easy job that would allow me to
finish (.) finish a degree course that I was doing outside
medicine and (.) so I went to the (name of establishment)
for all the wrong reasons and I wasn't entirely convinced
about the value of homeopathy on the onset of that job
either (.) what gradually I became aware of was (.)
a change in the ethos a change in the approach (.) a change
in the fact that the emphasis the different people put on the
person rather than all the various diagnostic labels

Extract 3 was from at the very beginning of the research
interview with the practitioner. Initially and in explicit
terms NS portrays homeopathy as an alternative treatment
option to 'normal treatment antibiotics' portrayed as the
accepted yardstick for practice. Rather than interpreting

such a sequence as merely the passing on of neutral accurate and factual information, NS's semi-biographical account sets the parameters for what is to be made discursively relevant. By adopting this before/after type of structure NS manages the intricacies of describing a personal 'trouble-tellings' experience while attending to the notion that any neutral competent observer would witness the usualness of the phenomena, in a similar situation and in a similar way, if in similar circumstances. Through a number of complex actions NS attends to and accomplishes undermining medicine as a way of talking up the potential therapeutic benefits of homeopathy.

As a way of building up his argument NS claims 'I've always been interested in alternative things ways of living,' which can be heard as an extreme-case formulation. The extremeness of 'always' adds weight to the authenticity of someone who has integrity to discuss 'alternative' topics. Second, this is followed with NS's utterance, 'but not really looked into alternative medicine very much', which can be heard as a way of inoculating against a possible counter-challenge on the grounds of self-interest, which is a way of managing a potential trouble in relation to personal accountability. The question of stake is a key area of focus during every interaction; people treat each other as having vested interest, desires, motivations, and allegiances – as having a stake in some position or other. If the speaker wants his/her version of events to be heard as the plain truth, then this has the potential to become problematic. People have different ways of managing stake, i.e. managing against inoculation. If one works up a description from an event in the past or from an accusation that insinuates blame to a particular person or a group, then there is the possibility of having ones' statement discounted on the grounds of 'stake and interest'. One may claim to have been sceptical (see Extract 4) and later to have been converted because of empirical evidence.

However, throughout accounts self-interest can be seen as a motivating factor and is treated so by the listener. Arguably, in all interaction the speaker will find ways to manage, stake and interest.¹⁷ On this occasion the stake, inoculation, works to counter the possible suggestion that NS had displayed a prior vested interest in promoting homeopathy to counter any potential challenges ('but not really looked into alternative medicine very much'). Third, in designing his account NS draws upon the mundane circumstances of constant ear infections that were not cured by 'normal antibiotics' set in a contrasting before/after feature. NS downgrades medicine 'we just thought it's not good enough' contrasted against bolstering homeopathy as a credible treatment option, 'I found a remedy that would stop ear infections instantly' which is an explicit reference to homeopathy having intrinsic and potentially positive therapeutic benefits.

Now consider Extract 4, here DH's account is constructed in a before/after formulation. DH displays a specific way of accounting, again intended to work-up the ordinariness of the event. This is achieved by depicting homeopathic practice within an everyday setting, resulting in

a potentially exceptional outcome – by deploying the ‘at first I thought. (mundane) ‘X’. then I realised’ (extraordinary) ‘Y’ normalising device for ‘extraordinary’ events.^{16,37} This way DH attends to the dilemma of stake and interest in his account. At the outset he claims ‘I wasn’t interested in homeopathy.’ followed by a range of features to support this notion. Next he claims ‘so I went to the (name of establishment) for all the wrong reasons and I wasn’t entirely convinced about the value of homeopathy on the onset of that job either’ (mundane ‘X’). Here, the rhetorical function of DH’s account highlights prevailing scepticism. DH goes on to invoke humanistic qualities he states ‘what I gradually became aware of was a change’; indicating that this is an occasion to talk up and promote an initial perceptual change in relation to homeopathic practices. DH attributes these traits to an apparent empirical experience in the capacity of a reliable witness (extraordinary ‘Y’). In producing the description ‘rather than all the various diagnostic labels’ DH is explicit in contrasting notions of conventional medical with homeopathic practices inferring that the ‘various diagnostic labels’ are attributed to the notion of disease in opposition to the humanistic approach as with homeopathy. With this formulation DH talks up the persuasiveness of his overall argument as objective experience, not solely contingent on his own individual agency adding facticity and authenticity to the claims being made. DH’s deployment of the ‘X’ then ‘Y’ device is the discursive work done to manage his personal accountability, stake and interest.

In presenting their claims in this way NS & DH boost the credibility of homeopathy by providing empirical evidence with a before/after formulation. They are not people who are promoting contentious information, rather just reasonable neutral competent observers, merely passing on the usualness of facts as they are.^{12,15} In other words they are ‘doing being ordinary’ as a way of building personal credibility as a reliable speaker.¹⁵ The potential downside is that by describing homeopathy in this fashion the inferences work to suggest that homeopathy is a ‘last-resort’ type of practice, yet again positioned on the fringes.⁴¹

Extract 5

- CC: is there anything else you’d like to tell me about homeopathy?
- HP: the other thing is there is considerable hostility to homeopathy by people who either don’t understand it (.) or are hostile because they badly need to fit it into a structure and they haven’t got that structure they (.) say it’s not scientific well it’s just as scientific as other sorts of medicine there is nothing not scientific about it

HP in a spontaneous response to an open-ended question regarding homeopathy, opts to refer to the ‘hostility’ directed towards homeopathy. The rhetorical design of her response

suggests that homeopathic practice is situated in problematic and difficult circumstances. At the same time by reporting what other people have said reinforces the objectivity of inferences being made.^{16,17} As evidence of unreasonable criticisms HP makes relevant ‘by people who either don’t understand it (.) or are hostile because they badly need to fit it into a structure and they haven’t got that structure’. What we see next is an explicit way of resisting and undermining the potential criticisms of homeopathy. As a way of talking up a defence of her practice she states ‘well it’s just as scientific as other sorts of medicine there is nothing not scientific about it’ providing anecdotal evidence of a genuine scientific basis to homeopathic practice. HP attempts to boost the credibility of homeopathy by defending homeopathic practice in a medical/homeopathy dyad. Yet in building an argument in this way works to portray medicine/medical discourse as the accepted yardstick for practice suggesting homeopathy is only valid when judged on conventional medical criteria. In the above extracts (3–5), attending to individual credibility is accomplished in ways that tend to marginalise homeopathic practice as a credible treatment option.^{19,30,31,41}

Discussion

The findings of this research come from a qualitative study involving 20 one-to-one interviews with homeopathic practitioners. They illustrate how homeopathic practice is constructed as a contingent social practice by people who have experienced and advocate treatment approach. Notably, the effects of practitioners’ accounts of homeopathic practice in ‘real life’ situations tend to distance homeopathy as a discipline in its own right; and thus continually marginalise it from mainstream acceptance.

Common assumptions in positivist research treat findings as quantifiable measurements which are accessed to represent underlying mechanisms and are representative of broader generalised patterns.^{10,11} In this study practitioners have built inter-subjective sense making through ‘real life’ interview setting.^{19,21} By applying DA as an analytical lens, it becomes apparent that there is no standard against which to measure contingently formulated social practices. Rather than being considered as fixed views the action (in situ) features of the multiple ways of accounting become the focus of enquiry. The ‘real life’ accounts produced in the context of one-to-one interviews have been considered as performative, social actions and as a topic of investigation in their own right. Alignment-with-medicine and ‘boostingthe-credibility-of-homeopathy’ are used by practitioners as ways of managing their own individual credibility. In line with previous discursive studies the findings suggest that specific social actions such as, blame, mitigation, accountability and so forth.^{12,14,33} Here practitioners’ ways of talking about homeopathic practice are grounded in defence of their practice located historically and make particular notions of conventional medicine relevant for consideration.

None of the notions identified above are fixed entities,

rather they are constituted in situated interview settings. The downside is, however, to position homeopathic practice as an alternative to wider notions of conventional medicine or a practice that is problematic resulting in a 'last-resort' type of practice.

The delicate discursive management these two strategies serve to show the practitioners as attentive when considering the effects of their ways of accounting for homeopathic practice in their response to the questions asked during the interview. All the practitioners portray variation in their own individual versions. In their responses to being asked about their homeopathic practices conventional medicine goes largely uncontested as the practitioners reassess, establish and negotiate their accounts in relation to conventional medicine within the analytical scheme.¹⁹

In the first strategy: alignment-with-medicine practitioner, participants D & HP defend homeopathic practice by aligning their practice with medicine and at the same time talk up homeopathy as an alternative. They rely on the introduction of particular descriptions or sets of descriptions representative of what is potentially a culturally available resource to constitute the homeopath/homeopathic doctor. Their interview talk and rhetorical formulations maximised the persuasive power of their descriptions. Significantly the use of such descriptions, participant D, 'I'm a homeopathic doctor' and HP 'I would make a distinction between homeopathic doctor and a homeopathic practitioner', are spontaneously invoked and not put to them in the preceding question from the researcher. This links to the broader social context of what is inferred by the references made to conventional medicine. This framework is used to defend, justify and legitimise conventional medicine as the taken-for-granted accepted yardstick for practice in interactional settings when accounting for their homeopathic practice.^{19,30,31}

Similarly, in the second strategy 'boosting-the-credibility-of-homeopathy', homeopathic practice is talked up as an alternative, something problematic and out of the ordinary. The practitioners work-up their descriptions by deploying before/after 'troubles-telling' sequences or by undermining potential criticisms; again combining with various rhetorical devices.^{38,40} In extracts 3 & 4 homeopathic practice is presented as a 'last-resort' suggesting that credibility is an ongoing issue. Participants DH & NS, attend to the credibility of their own practices by portraying themselves as ordinary people just explaining the 'ordinariness' of facts as they are.^{14,15} HP defends potential criticisms in an apparent cultural scepticism about the validity of homeopathic practice. For all these practitioners (DH, NS & HP), individual credibility is accomplished only through specific constructions of homeopathy that orient homeopathy as a sensitive practice. This again marginalises homeopathic practice from mainstream acceptance by contrasting it to notions of conventional medicine and medical discourse.

I draw on the Foucauldian notion of marginalisation – the 'scientific' institution as a metaphor – to constitute the

‘what is?’ and ‘what is not?’, wider scepticism about the validity of homeopathic practice.^{33,41} Marginalisation is present when a dominant majority is at the centre of the legitimisation of the institution (conventional medical practice²) with diverse marginalised practices represented at the periphery (homeopathic practice as an ‘alternative’ type of practice). The boundaries of the institution are defined by ‘acceptable practices’ which are negotiated, resisted and made relevant by the members’ methods for sense making. The notion of what is an acceptable, taken-for-granted or ‘normative practice’ is socially constructed and constituted over multiple discourses. In other words, through their talk participants rely on culturally shared meanings and expectations when (re-)producing intelligible accounting practices and actions. In so doing, the effect of marginalisation varies between interactional contexts and settings. The findings show the development that configurations and continuity of medical discourse (truth claims/scientific knowledge/metanarrative) is a cultural, sociopolitically and historically informed production and not solely a socially neutral phenomenon.^{19,30,31,41}

These findings can nonetheless be used to inform homeopathic practice by highlighting the ways practitioners talk about homeopathy. The range of forms and ways of accounting identified here are not exhaustive and the practitioners explicitly provided variations in their versions.¹⁹ Practitioners were observed to consistently evaluate homeopathic practice in contrast with conventional medicine. In so doing, they continually position homeopathy as alternative to conventional medicine, reproducing and sustaining these notions in their own individual and spontaneously invoked terms. The wider implications indicate that homeopathic continues to be demarcated, marginalised and positioned on the fringes of the medical environment basis and thus homeopathic practice is continually void of a persuasive political voice as noted by Degele.^{3,4} By examining homeopathic practice on its own terms, DA offers possibilities to re-constitute notions of homeopathic practice. But DA does not provide answers or factual claims, rather, it offers ways of understanding how to evaluate and build positively upon the ‘real life’ contexts.

Conclusion

In this study the environment of the research interview was used as a site of social enquiry to reassess and re-negotiate the taken-for-granted discursive parameters. I argue that one novel way of achieving progress is by developing homeopathic practice further as a discipline in its own right, until this is addressed the credibility/status homeopathic practice receives in professional, lay and media contexts will continue characterised by apparent underachievement – located in a culture-of-scepticism. On an optimistic note, these horizons show how possibilities can be created to reduce the effect of continuing marginalisation from mainstream acceptance.

Participants list

Practitioners

D Female 60s
HP Female 50s
NS Male 50s
DH Male 50s

Researcher

CC Male 30s

Acknowledgements

I thank all the participants for sharing their valuable experiences: delegates at the British Homeopathic Congress 2006, Carol Gray for her helpful comments on an earlier draft – and the progressive thought and insightful recommendations provided by the anonymous reviewer.

References

- 1 Atkinson P. Medical talk and medical work: the liturgy of the clinic. London: Sage Publications, 1995, pp 28–90.
- 2 Foucault M. The birth of the clinic. London: Tavistock Publications Limited, 1993, pp 195–199.
- 3 Degele N. On the margins of everything: homeopathy as science, anti-science, or semi-science? University of Freiburg 2002, pp 1–19.
- 4 Degele N. On the margins of everything: doing performing and staging science in homeopathy. *Sci Technol Human Values* 2005; 30: 111–136.
- 5 Baggot R. Health and healthcare in Britain. 3rd edn, Basingstoke: Palgrave MacMillan, 2004, pp 29–54.
- 6 Gilbert GN, Mulkay M. Opening Pandora's box: a sociological analysis of scientists discourse. Cambridge: Cambridge University Press, 1984, pp 18–39.
- 7 Ruusuvuori J. Managing affect: integration of empathy and problem solving in healthcare encounters. *Discourse Stud* 2007; 9(5): 597–622.
- 8 Seymour-Smith S, Wetherell M, Phoenix A. 'My wife ordered me to come!': a discursive analysis of doctors' and nurses accounts of men's use of general practitioners. *J Health Psychol* 2002; 7: 253–267.
- 9 Brewster O'Reilly W. Organon of the medical art by DR. Samuel Hahnemann. Washington: Birdcage Books, 1996, pp 8–57.
- 10 Linde K, Clausius N, Ramirez G, et al. Are the clinical effects of homeopathy placebo effects? A meta-analysis of placebo controlled trials. *Lancet* 1997; 350: 834–843.
- 11 Taylor MA, Reilly D, Llewellyn-Jones R, McSharry C, Atkinson TC. Randomised controlled trial of homeopathy versus placebo in perennial allergic rhinitis with overview of four trial series. *Br Med J* 2000; 2: 471–476.

- 12 Edwards D, Potter J. Discursive psychology. London: Sage Publications, 1992, Chap 7, pp 153–177.
- 13 Horton-Salway M. Narrative identities and the management of personal accountability in talk about ME: a discursive psychology approach to illness narrative. *J Health Psychol* 2001; 6: 247–259.
- 14 Stoke E, Hepburn A. ‘You can hear a lot through the walls’: noise formulations in neighbour complaints. *Discourse Soc* 2005; 16(5): 647–673.
- 15 Sacks H. Harvey Sacks – lectures on conversation, vol. I. Edited by G. Jefferson with an introduction from Emanuel A. Schegloff, 1992, pp 215–221.
- 16 Wooffitt R. Telling tales of the unexpected: the organisation of factual discourse. Hemel Hempstead: Harvest Wheatsheaf, 1992, pp 102–154.
- 17 Potter J. Representing reality: discourse, rhetoric and social construction. London: Sage Publications, 1996. Chap 4–7, pp 97–201.
- 18 Ruusuvuori J. Empathy and sympathy in action: attending to patients’ troubles in Finnish homeopathic and GP consultations. *Soc Psychol Q* 2005; 68: 204–222.
- 19 Wetherell M. Positioning and interpretative repertoires: conversation analysis and post-structuralism in dialogue. *Discourse Soc* 1998; 9: 387–412.
- 20 Simon A, Wooffitt R. Negotiating consciousness: parapsychology and the social organisation of reports of mental states. In: Hepburn A, Wiggins S (eds). *Discursive Research in Practice: New Approaches to Psychology and Interaction*. Cambridge: Cambridge University Press, 2007, p. 70–87.
- 21 Potter J, Hepburn A. Qualitative interviews in psychology – problems and possibilities. *Qual Res Psychol* 2005; 2: 281–307.
- 22 Atkinson JM, Heritage J. Structures of social action: studies in conversation analysis. Cambridge: Cambridge University Press, 1984, pp ix–xvi.
- 23 Barnes RK, Moss D. Communicating a feeling: the social organisation of ‘private thoughts’. *Discourse Stud* 2007; 9(2): 123–148.
- 24 Gergen KJ. Social construction in context. London: Sage Publications, 2001, pp 163–168.
- 25 Gergen KJ. Construction in contention: toward consequential resolutions. *Theory Psychol* 2001; 11: 419–432.
- 26 Austin JL. How to do things with words. Oxford: Clarendon Press, 1962, pp 1–12.
- 27 Garfinkel H. Studies in ethnomethodology. Englewood Cliffs, NJ: Prentice Hall, 1967, pp 1–75.
- 28 Heritage J. Garfinkel and ethnomethodology. Cambridge: Polity

Press, 1984, pp 103–231.

29 Schelgloff EA. Whose text? Whose context? *Discourse Soc* 1997; 8: 165–187.

30 Edley N. Analysing masculinity: interpretative repertoires, ideological dilemmas and subject positions. In: Wetherell M, Taylor S, Yates SJ (eds). *Discourse as Data: a Guide for Analysis*. Milton Keynes: The Open University, 2001. p. 189–228. Chap 5.

31 Burman E, Parker I. Introduction – discourse analysis: the turn to the next. In: Burman E, Parker I (eds). *Discourse Analytic Research: Repertoires and Readings of Texts in Action*. London: Routledge, 1993. p. 1–13. Chap 1.

32 Wooffitt R. Conversation analysis and discourse analysis: a comparative and critical introduction. London: Sage Publications, 2005, pp 137–157.

33 Edwards D, Potter J. Language and causation: a discursive action model of description and attribution. *Psychol Rev* 1993; 100: 23–41.

34 Potter J. Discourse analysis as a way of analysing naturally occurring talk. In: Silverman D (ed). *Qualitative Research: Theory, Method and Practice*. London: Sage Publications, 2004, p. 200–221. Chap 10.

35 Jefferson G. List construction as a task and interactional resource. In: Psathas G (ed). *Interactional Competence*. Washington: University Press of America, 1990. p. 122–143.

36 Pomerantz AM. Extreme case formulations: a new way of legitimising claims. *Hum Stud* 1986; 9(1): 219–230.

37 Jefferson G. ‘‘At first I thought’’: a normalising device for extraordinary events’, unpublished manuscript. Katholieke Hogeschool: Tilburg. 1984, pp 131–159.

38 Edwards D. Categories are for talking: on the cognitive and discursive bases of categorisation. *Theory Psychol* 1991; 1(14): 515–542.

39 Jefferson G. One stepwise transition from talk about trouble to inappropriately next-positioned matters. In: Atkinson JM, Heritage J (eds). *Structures of Social Science in Conversation Analysis*. Cambridge: Cambridge University Press, 1984. p. 192–222. Chap 9.

40 Jefferson G, Lee J. The rejection of advice: managing the problematic convergence of a ‘troubles telling’ and a ‘service encounter.’ In: Drew P, Heritage J (eds). *Talk at Work: Interaction in Institutional Settings*. Cambridge: Cambridge University Press, 1992, p. 192–222. Chap 15.

41 Foucault M. *Power/knowledge: selected interviews and other writings 1992–1997*. New York: Prentice Hall, 1980, pp 78–108.

Homeopathy (2008) 97, 76–82 _ 2008 The Faculty of Homeopathy
doi:10.1016/j.homp.2008.02.001, available online at <http://www.sciencedirect.com>